

UNIVERSITY ORTHOPEDICS PATIENT HISTORY FORM

NAME: _____ AGE: _____ DOB: _____ DATE: _____

REFERRING DOCTOR: _____ DOMINANT HAND: RIGHT LEFT

PRESENT COMPLAINT: _____

DATE OF ONSET: _____ SIDE: RIGHT LEFT

REVIEW OF SYSTEMS:

- | | | | | |
|---|--|--|--|--|
| Central Nervous System: <input type="checkbox"/> No Problems | <input type="checkbox"/> Headache | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Dizziness |
| Cardiovascular: <input type="checkbox"/> No Problems | <input type="checkbox"/> Chest Pain or Tightness | <input type="checkbox"/> Shortness of Breath | | |
| Respiratory: <input type="checkbox"/> No Problems | <input type="checkbox"/> Cough | <input type="checkbox"/> Sputum Production | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing |
| Gastrointestinal: <input type="checkbox"/> No Problems | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn |
| Genitourinary: <input type="checkbox"/> No Problems | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Discharge | |
| Hematologic: <input type="checkbox"/> No Problems | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin Color Change | <input type="checkbox"/> Frequent Injections |
| Musculoskeletal: <input type="checkbox"/> No Problems | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Muscle Pain |
| ENT: <input type="checkbox"/> No Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Nasal Drainage | |
| Eyes: <input type="checkbox"/> No Problems | <input type="checkbox"/> Pain | <input type="checkbox"/> Redness | <input type="checkbox"/> Problems with Sight | |
| Skin: <input type="checkbox"/> No Problems | <input type="checkbox"/> Rashes | <input type="checkbox"/> Flaky or Dry Patches | <input type="checkbox"/> Frequent Pimples | |

PAST MEDICAL HISTORY:

- Musculoskeletal:** No Problems
 Osteoarthritis Rheumatoid arthritis Fibromyalgia Other _____
- Eye Problems? _____ Ear Problems? _____
- Central Nervous System:** No Problems
 Stroke Seizures Multiple Sclerosis Alzheimer's Other _____
- Cardiovascular:** No Problems
 Heart Attack (Date: _____) Angina (Chest pains) High BP Irregular Heart Beat
 Valve Problem Phlebitis (Leg Vein Clots)
- Pulmonary:** No Problems
 Chronic Bronchitis Asthma Tuberculosis Pulmonary Embolus (Lung Blood Clot) Emphysema
- Gastrointestinal:** No Problems
 Reflux Peptic Ulcer Crohn's Disease Other _____
- Hematologic:** No Problems
 Hepatitis Jaundice HIV Anemia Other _____
- Genitourinary:** No Problems
 Kidney Disorder Bladder Disorder Prostate Disorder Other _____
- Endocrine:** No Problems
 Diabetes Thyroid Parathyroid Other _____
- Cancer:** Yes No If yes, type: _____ Oncology Doctor: _____
- Mental Health:** No Problems
 Anxiety Depression Other _____

PAST SURGICAL HISTORY: No history of surgery

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

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MEDICATIONS:

None

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Are you on: Coumadin Aspirin Lovenox Glucophage Herbs _____

SOCIAL HISTORY:

Type of work: _____ Married Single Divorced Widowed

Smoke? If so, amount: _____ Alcohol? If so, amount: _____ Drug Use? If so, type: _____

FAMILY HISTORY: None Stroke Diabetes Heart Lung Cancer Bleeding Disorder

MEDICATION ALLERGIES: No known medication allergies

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____

Do you have a latex allergy? Yes No

Do you or any family members have: Anesthetic Complications? Yes No Malignant Hyperthermia? Yes No

CARDIOVASCULAR RISK PROFILE:

History of MI Angina Coronary Artery Bypass Grafting Stent Stroke
 Hypertension High Cholesterol Positive family history of MI under 40 years of age

Reviewed by: _____
(Nurse/Tech's Signature)

(Physician's Signature)