

# CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE HISTORY FORM 1 of 3

The following information is very important to your health. Please take the time to fully and accurately fill out this 3 page form.

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_  
LAST FIRST MI

## MEDICAL HISTORY NONE

Have you ever had (Please check and give approximate date of diagnosis)

- |  |  |
|--|--|
| <p>(age/date)</p> <ul style="list-style-type: none"><li><input type="checkbox"/> _____ Heart attack</li><li><input type="checkbox"/> _____ High blood pressure</li><li><input type="checkbox"/> _____ Stroke</li><li><input type="checkbox"/> _____ Diabetes</li><li><input type="checkbox"/> _____ Epilepsy/Seizures</li><li><input type="checkbox"/> _____ Asthma</li><li><input type="checkbox"/> _____ Stomach ulcer</li><li><input type="checkbox"/> _____ Hiatal hernia</li><li><input type="checkbox"/> _____ Kidney disease</li><li><input type="checkbox"/> _____ Liver disease</li><li><input type="checkbox"/> _____ Nasal polyps</li><li><input type="checkbox"/> _____ Blood clot or clotting disorder</li><li><input type="checkbox"/> _____ Deep venous thrombosis (DVT)</li><li><input type="checkbox"/> _____ Phlebitis</li><li><input type="checkbox"/> _____ Anesthetic Problems</li></ul> <p><input type="checkbox"/> _____ Blood transfusion (explain) _____</p> <p><input type="checkbox"/> _____ Bleeding disorders (explain) _____</p> <p><input type="checkbox"/> _____ Hepatitis (circle type) A B C NON A-NON B</p> <p><input type="checkbox"/> _____ Sexually transmitted disease (explain) _____</p> <p><input type="checkbox"/> _____ AIDS</p> | <p>(age/date)</p> <ul style="list-style-type: none"><li><input type="checkbox"/> _____ Rheumatoid arthritis</li><li><input type="checkbox"/> _____ Osteoarthritis</li><li><input type="checkbox"/> _____ Gout</li><li><input type="checkbox"/> _____ Lupus</li><li><input type="checkbox"/> _____ Scleroderma</li><li><input type="checkbox"/> _____ Polio</li><li><input type="checkbox"/> _____ Lyme disease</li><li><input type="checkbox"/> _____ Paget's disease</li><li><input type="checkbox"/> _____ Bone or joint infection</li><li><input type="checkbox"/> _____ Thyroid disease</li><li><input type="checkbox"/> _____ Osteoporosis</li><li><input type="checkbox"/> _____ Tuberculosis</li><li><input type="checkbox"/> _____ Bone tumors</li><li><input type="checkbox"/> _____ Fracture/Broken Bone</li><li><input type="checkbox"/> _____ Cancer _____</li><li><input type="checkbox"/> _____ Other bone or joint disease _____</li><li><input type="checkbox"/> _____ Other _____</li></ul> |
|--|--|

## SURGICAL HISTORY NONE

What operations have you had?  
(Please list approximate date at surgery)

- (age/date)
- \_\_\_\_\_ Hysterectomy/removal of ovaries
  - \_\_\_\_\_ Appendectomy
  - \_\_\_\_\_ Tubal ligation
  - \_\_\_\_\_ Tonsils
  - \_\_\_\_\_ Gall bladder
  - \_\_\_\_\_ Neck
  - \_\_\_\_\_ Back
  - \_\_\_\_\_ Extremity \_\_\_\_\_
  - \_\_\_\_\_ Other \_\_\_\_\_
  - \_\_\_\_\_ Other \_\_\_\_\_
  - \_\_\_\_\_ Other \_\_\_\_\_
  - \_\_\_\_\_ Other \_\_\_\_\_

## FAMILY HISTORY NONE

Does/did anyone in your family have any of the following?  
(Include parents, grandparents, siblings)

- (relative)
- \_\_\_\_\_ Heart disease
  - \_\_\_\_\_ High blood pressure
  - \_\_\_\_\_ Diabetes
  - \_\_\_\_\_ Cancer \_\_\_\_\_
  - \_\_\_\_\_ Bleeding disorder
  - \_\_\_\_\_ Developmental delay
  - \_\_\_\_\_ Mental illness
  - \_\_\_\_\_ Substance abuse
  - \_\_\_\_\_ Osteoporosis
  - \_\_\_\_\_ Scoliosis
  - \_\_\_\_\_ Rheumatoid arthritis
  - \_\_\_\_\_ Scleroderma
  - \_\_\_\_\_ Lupus
  - \_\_\_\_\_ Paget's Disease
  - \_\_\_\_\_ Blood Clot or Clotting Disorder
  - \_\_\_\_\_ Anesthetic Problems

## SOCIAL HISTORY

- Do you use tobacco?  
 Cigarettes  Chewing NO  YES  If YES, how much? For how long? \_\_\_\_\_
- Do you drink alcohol? NO  YES  If YES, how much? For how long? \_\_\_\_\_
- Do you use any street drugs? NO  YES  Explain how much? For how long? \_\_\_\_\_
- Do you have any special interests or hobbies? (list how often you do your hobbies) \_\_\_\_\_
- Do you use any assist devices for walking?  Crutches  Cane  Walker  Wheelchair  Prosthetic  Other \_\_\_\_\_
- How long have you used this device? \_\_\_\_\_



**CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE – HISTORY FORM PAGE 3 of 3**

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 LAST FIRST MI

**REVIEW OF SYSTEMS: Check any of the following symptoms you have experienced WITHIN THE PAST SIX MONTHS. Check NONE if none apply.**

**GENERAL**  
 **NONE**  
 Fever or Chills  
 Lack of appetite  
 Fatigue  
 Weakness  
 Recent change in usual weight  
 Other \_\_\_\_\_

**RESPIRATORY**  
 **NONE**  
 Difficulty breathing  
 Persistent cough  
 Shortness of breath  
 Other \_\_\_\_\_

**PSYCHOLOGICAL**  
 **NONE**  
 Depression  
 Tension  
 Nervousness  
 Anxiety disorder  
 Bipolar disorder  
 Other \_\_\_\_\_

**EYES**  
 **NONE**  
 Eye Infection  
 Change in vision  
 Other \_\_\_\_\_

**GASTROINTESTINAL**  
 **NONE**  
 Heartburn/esophageal reflux  
 Nausea  
 Constipation  
 Loose bowels/diarrhea  
 Other \_\_\_\_\_

**SKIN**  
 **NONE**  
 Bruise easily  
 Rash or Hives  
 Other \_\_\_\_\_

**EARS/NOSE/MOUTH/THROAT**  
 **NONE**  
 Earache  
 Infection or drainage  
 Polyps  
 Nasal congestion  
 Sore throat  
 Sores in mouth  
 Other \_\_\_\_\_

**URINARY**  
 **NONE**  
 Recent urinary tract infection  
 Pain or burning with urination  
 Kidney Stones  
 Other \_\_\_\_\_

**ENDOCRINE**  
 **NONE**  
 Excessive urination  
 Excessive appetite  
 Excessive thirst  
 Other \_\_\_\_\_

**CARDIOVASCULAR**  
 **NONE**  
 Chest pain  
 Irregular heartbeat  
 Palpitations  
 Heart murmur  
 Heart Attack  
 Stroke  
 Other \_\_\_\_\_

**MUSCULOSKELETAL**  
 **NONE**  
 Painful or stiff joints  
 Cramps in muscles  
 Infection of joint  
 Broken Bone/Fracture  
 Other \_\_\_\_\_

**HEMATOLOGY/LYMPH**  
 **NONE**  
 History of transfusion  
 Bleeding disorder  
 Hepatitis  
 AIDS  
 Other \_\_\_\_\_

**NEUROLOGIC**  
 **NONE**  
 Muscle weakness  
 Numbness or tingling  
 Loss of sensation  
 Other \_\_\_\_\_

**FEMALE HEALTH HISTORY**  
 **NONE**  
 Age of onset of menstrual period \_\_\_\_\_  
 Age when periods stopped (menopause) \_\_\_\_  
 First day of last menstrual period \_\_\_\_\_  
 Last mammogram \_\_\_\_\_  
 Last Pap exam \_\_\_\_\_

**REVIEWED ALL. NEGATIVE EXCEPT THOSE CHECKED**

The information completed on this three-page History Form is true and correct to the best of my belief.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 MA Signature – reviewed pages 1 through 3 with patient

\_\_\_\_\_  
 Date