

St Peters Bone & Joint Surgery, Inc. ORTHOPAEDIC HISTORY

Name _____

Birth Date _____

CURRENT MEDICATION(S)

Name of Medicine	Dose	How long have you taken it?	Side Effects?

ALLERGIES:

Name of Medicine/Substance	Type of Reaction

Are you allergic to latex? Yes No I don't know

VITALS / CHIEF COMPLAINT

Height _____ (ins) Weight _____

What problem brings you to the office today? _____

HISTORY of CURRENT PROBLEM

When did the problem start? _____ How did the problem start? _____

Did the injury happen at work? Yes No

Is the injury from motor vehicle accident? Yes No

What tests have you had for this problem? X-Ray MRI Other _____

What treatments have you had for this problem? _____

PAIN RATING

Are you experiencing pain? Yes No Describe the pain. _____

Please circle the number that represents the amount of pain you are having today:

(no pain)	0	1	2	3	4	5	6	7	8	9	10	(worst pain of your life)
-----------	---	---	---	---	---	---	---	---	---	---	----	---------------------------

Does it disturb your sleep? Yes No

What makes it feel better? _____ Worse? _____

What are you now unable to do because of this condition? _____

PAST MEDICAL HISTORY

- Taking blood thinner medication? Yes
- Hypertension? Yes
- Angina pectoris? Yes
- Coronary artery disease? Yes
- Congestive heart failure? Yes
- Asthma? Yes
- COPD? Yes
- Diabetes? Yes
- HIV infection? Yes
- Cancer? Yes
- Rheumatoid arthritis? Yes
- Esophageal reflux? Yes
- Thrombophlebitis? Yes
- Osteoporosis? Yes
- Gout? Yes
- Sleep apnea? Yes
- Prostate disorders? Yes
- Kidney (renal disorders)? Yes

SOCIAL HISTORY

- Social history unchanged Yes No
- Alcohol use Yes No
- Smoking Yes No
- Drug use Yes No

FAMILY HISTORY

- Family history unchanged Yes No
- Cancer Yes No
- Heart Disease Yes No
- Hypertension Yes No
- Osteoarthritis Yes No

PAST SURGICAL HISTORY

- | | | | |
|------------------------------|------------------------------|------|-------|
| Back surgery? | <input type="checkbox"/> Yes | Date | _____ |
| Hip replacement? | <input type="checkbox"/> Yes | Date | _____ |
| Knee replacement? | <input type="checkbox"/> Yes | Date | _____ |
| Rotator cuff repair? | <input type="checkbox"/> Yes | Date | _____ |
| Cataract surgery? | <input type="checkbox"/> Yes | Date | _____ |
| Tonsillectomy/Adenoidectomy? | <input type="checkbox"/> Yes | Date | _____ |
| Thyroid surgery? | <input type="checkbox"/> Yes | Date | _____ |
| Appendectomy? | <input type="checkbox"/> Yes | Date | _____ |
| Gall bladder surgery? | <input type="checkbox"/> Yes | Date | _____ |
| Hernia repair? | <input type="checkbox"/> Yes | Date | _____ |
| Hemorrhoidectomy? | <input type="checkbox"/> Yes | Date | _____ |
| Cardiac Pacemaker? | <input type="checkbox"/> Yes | Date | _____ |
| Hysterectomy? | <input type="checkbox"/> Yes | Date | _____ |
| Cesarean section? | <input type="checkbox"/> Yes | Date | _____ |
| Prostate surgery? | <input type="checkbox"/> Yes | Date | _____ |
| Other | <input type="checkbox"/> Yes | Date | _____ |

REVIEW of SYSTEMS

Systemic Symptoms

- Weight change Yes
- Chills Yes
- Fever Yes
- Night sweats Yes
- Feeling tired or poorly (malaise) Yes
- Other constitutional symptoms Yes

Pulmonary Symptoms

- Shortness of breath Yes
- Cough Yes
- Coughing up blood (hemoptysis) Yes
- Night sweats Yes
- Wheezing Yes
- Other pulmonary symptoms Yes

REVIEW of SYSTEMSHEENT Symptoms

- Headache Yes
 Eyesight problems Yes
 Nosebleed (epistaxis) Yes
 Other head-related symptoms Yes

Neck Symptoms

- Neck pain Yes
 Neck stiffness Yes
 Lump or swelling in the neck Yes
 Other neck symptoms Yes

Cardiovascular Symptoms

- Chest pain or discomfort Yes
 Fast heart rate Yes
 Palpitations Yes
 Other cardiovascular symptoms Yes

Gastrointestinal Symptoms

- Difficulty swallowing (dysphagia) Yes
 Heartburn Yes
 Vomiting Yes
 Abdominal pain Yes
 Diarrhea Yes
 Other gastrointestinal symptoms Yes

Genitourinary Symptoms

- Hematuria Yes
 Dysuria Yes
 Increased urinary frequency Yes
 Other genitourinary symptoms Yes

Skin Symptoms

- Pruritis Yes
 Skin lesions Yes
 Rashes Yes
 Other skin symptoms Yes
 Easy bleeding Yes
 Easy bruising tendency Yes
 Other hematological symptoms Yes

Endocrine Symptoms

- Excessive sweating Yes
 Excessive thirst (polydipsia) Yes
 Other endocrine symptoms Yes
 Sleep disturbances Yes

Hematological Symptoms

- Easy bleeding Yes
 Easy bruising tendency Yes
 Other hematological symptoms Yes

Neurological Symptoms

- Dizziness Yes
 Vertigo Yes
 Motor disturbances Yes
 Sensory disturbances Yes
 Other neurological symptoms Yes

Psychological Symptoms

- Sleep disturbances Yes
 Anxiety Yes
 Depression Yes
 Other psychological symptoms Yes

 Patient/Guardian Signature

 Date