

**St. Peters Bone & Joint
ORTHOPAEDIC HISTORY FORM (Page 1)**

Name: _____

Today's Date: _____

SS#: _____ - _____ - _____

Date of Birth: _____

Primary Care Physician: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Current problem is the result of a(n): **Check** all that apply.

- Car Accident Work Accident Accident

Other: _____

This occurred during: **Check** all that apply.

- Lifting Pulling Pushing Twisting Falling Bending Reaching Squatting
 Hit by Object Not Known

Height _____ Weight _____

Medication	Dose	How Long?	Side Effects

Allergies:

REVIEW OF SYSTEMS

Are you currently or have you had problems with your:

Yes/No Describe all YES responses

- Eyes _____
- Ears, Nose, Throat _____
- Lungs, Breathing _____
- Digestion _____
- Bowel Movement _____
- Bladder problem _____
- Diabetes _____
- High Blood Pressure _____
- Bleeding problems _____
- Balance problems _____
- Numbness / tingling _____
- Blackout / fainting _____
- Psychological Problems _____
- AIDS _____
- Cancer _____
- Arthritis _____
- Polio _____
- TB _____
- Epilepsy _____

**St. Peters Bone & Joint
ORTHOPAEDIC HISTORY FORM (Page 2)**

Name: _____

Date of Birth: _____

PAST MEDICAL HISTORY

Surgeries / Hospitalizations	Year	Complications

Have you ever had general anesthesia? No Yes

Have any problems with anesthesia? No Yes Describe: _____

FAMILY HISTORY

Member	Alive/Deceased	Age	Health Status or cause of death
Grandmother (mom's)			
Grandfather (mom's)			
Grandmother (dad's)			
Grandfather (dad's)			
Father			
Mother			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Sister / Brother			

SOCIAL HISTORY

Work in the home Employed (occupation _____) Student

Single Married Divorced Separated Widowed

Children: No Yes # _____

Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

Are you on a special Diet? No Yes Describe: _____

History of substance abuse? No Yes What: _____

Smoking Currently? No Yes ___Packs per day for ___ years.

Quit smoking? This year > 1 year > 5 years > 10 years

Previously smoked ... _____ Packs per day for ___ years.

Drink Alcohol? None Daily 1-2 x/week 1-2 x/month

Reviewed by: _____

Date: _____

Physician's Signature