

REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following health problems?

N2E3
(MS)

1) M/S • Have you had a prior problem with this same Orthopaedic condition in the past? Y N (explain below)

• Have you had prior Back Pain Joint Swelling Prior Fracture Arthritis _____

N3E4
(2-9)

2) ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N If yes, please list _____

3) ARE YOU A DIABETIC? Y N TREATMENT: Insulin Oral Meds Diet None

N4,5
E5
(14)

(Please check any that apply, or mark None)

None Year

Explain Details/Comments

4) CON weight loss Loss of appetite Fever Cancer _____

5) EYE Glasses Contacts Double Vision Cataract _____

6) ENT Hearing Loss Hoarseness Ringing in Ears _____

7) CV High blood pressure Heart attack Blood clots _____

8) RS Asthma Cough Pneumonia Short of Breath TB _____

9) GI Stomach ulcer Hepatitis Blood in Stool _____

10) GU Pain with Urination Blood in Urine Kidney disease _____

11) SK Skin Ulcers Rash Lumps _____

12) NEU Seizures Stroke Balance Problem Headaches _____

13) PSY Depression Nervousness Sleep disorder _____

14) HEM Easy bleeding Easy bruising Anemia _____

PAST MEDICAL HISTORY

N3/E4
(1)

★ WHAT MEDICATIONS DO YOU TAKE? None Please list with dosage: _____

N4,5
E5
(1)

ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BLOOD THINNERS? Y N If yes, (type) _____

PAST HOSPITALIZATIONS (Not for surgery) None _____

PAST SURGICAL HISTORY: What operations have you had? When? None _____

Have you ever had a reaction to anesthesia? Y N

N4,5
E5
(1)

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

★ Any direct relative with the same Orthopaedic condition you are being seen for today? Y N _____

Diabetes Y N _____ High Blood Pressure Y N _____ Heart disease Y N _____ Arthritis Y N _____

N4,5
E5
(1)

SOCIAL HISTORY:

★ Do you use tobacco? Y N Packs per day _____ Alcohol use? Y N How often? Daily Other ____/ week

Marital History: M S D W How many people live with you? _____

Occupation: _____ Student Employer: _____

Are you currently working? Y N If no, how long have you been off work? _____

For Office use only

Reviewed for completeness by _____ Date ____/____/____ Reviewed by MD _____ Date ____/____/____

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