

# Orthopaedic Trauma Specialist Patient History Form

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Primary Doctor \_\_\_\_\_

Date of Injury \_\_\_\_\_ (circle) Right/Left Date of Surgery \_\_\_\_\_ (circle) Right/Left

## Current Medications and Dosage

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

## Drug/Food Allergies

## Previous Surgeries or Hospitalizations (With Dates)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

## Family Medical History (Major illnesses that run in your family)

Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ Lung Disease \_\_\_\_\_  
Cancer \_\_\_\_\_ Type of Cancer \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_ Other \_\_\_\_\_

## Social History

Marital Status (please circle one) Married Single Divorced Widow/Widower Separated

If married, what is the name of your spouse? \_\_\_\_\_

Your Occupation \_\_\_\_\_

Do you smoke cigarettes? Yes \_\_\_ No \_\_\_ If yes, how many years have you smoked? \_\_\_\_\_

How many packs smoked daily? ½ \_\_\_ 1 \_\_\_ more than 2 \_\_\_ If no, but you quit smoking, how many years did you smoke? \_\_\_\_\_

How many packs smoked daily? ½ \_\_\_ 1 \_\_\_ more than 2 \_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_ If Yes, how often do you drink alcohol? \_\_\_\_\_

## Please check the which of the following conditions you have or have had in the past:

- |                        |                         |                        |                       |
|------------------------|-------------------------|------------------------|-----------------------|
| ___ Acid reflux        | ___ Depression          | ___ Kidney Disease     | ___ Scarlet Fever     |
| ___ Aids               | ___ Diabetes            | ___ Liver Disease      | ___ Stroke            |
| ___ Alcoholism         | ___ Drug Dependency     | ___ Migraines          | ___ Teeth/Gum Disease |
| ___ Anxiety            | ___ Emphysema           | ___ Mononucleosis      | ___ Thyroid Problems  |
| ___ Arthritis          | ___ Epilepsy            | ___ Multiple Sclerosis | ___ Tuberculosis      |
| ___ Asthma             | ___ Glaucoma            | ___ Osteoporosis       | ___ Ulcers            |
| ___ Bladder Problems   | ___ Goiter              | ___ Pace maker         | ___ Sleep Apnea       |
| ___ Bleeding Disorders | ___ Heart Disease       | ___ Pneumonia          | ___ Other: _____      |
| ___ Bronchitis         | ___ Hepatitis           | ___ Polio              | _____                 |
| ___ Cancer             | ___ High Blood Pressure | ___ Prostate Problem   | _____                 |
| ___ Cataracts          | ___ HIV Positive        | ___ Rheumatic Fever    | _____                 |