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._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Drug/Food Allergies _____

Previous Surgeries or Hospitalizations (With Dates)

1._____ 4._____
2._____ 5._____
3._____ 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	_____