Orthopaedic Trauma Specialists 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) Single Married Divorced Separated Widowed
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?_____

Review of Systems: Are you currently having or have you had problems with: (Please Check)

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

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_____

Office Use Only
Reviewed By:

_____

Date: _____