Total Orthopedic Care
Medical History & Review of Systems

This will assist your doctor in getting the complete health picture of your condition and assist in determining medication interactions and such.

Name:______________________________ Age:__________ Date:______________

Primary Care Doctor:______________________________ Insurance:______________

HPI: What is your CHIEF COMPLAINT?______________________________

Briefly, how did this occur?______________________________

How long has this been bothering you? (DURATION)______________weeks/months.

What is the Quality of pain like? Please Circle: Sharp Stabbing Burning Tingling Dull

The Timing of the pain is? Please Circle: Constant Intermittent

On a scale, with 10 being the worst, how would you rate the SEVERITY of your pain? ______/10

What treatments have you had for your problem? Ibuprophen/Aleve/Tylenol, Physical Therapy, X-ray, MRI

ALLERGIES: ______________________________

ALLERGY TO LATEX? PLEASE CIRCLE: YES or NO

MEDICAL HISTORY:

Hypertension......................	Yes	no	Anxiety/Depression...........	yes	no	DVT/PE...................	yes	no
High Cholesterol......	yes	no	Gout...........................	yes	no	Hepatitis/Liver Disease...........	yes	no
Heart Attack............	yes	no	Thyroid Disease...................	yes	no	Kidney Disease.............	yes	no
AFIB........................	Yes	no	Arthritis....................	yes	no	Cancer, type:__________.	yes	no
Diabetes......................	yes	no	TIA/Stroke................	yes	no	Other:__________________		
Asthma....................	yes	no	HIV/AIDS..............................	Yes	no	____________________		

PAST SURGICAL HISTORY AND DATES: ______________________________

____

FAMILY HISTORY:

Hypertension......................	Yes	no	Anxiety/Depression...........	yes	no	DVT/PE...................	yes	no
High Cholesterol......	yes	no	Gout...........................	yes	no	Hepatitis/Liver Disease...........	yes	no
Heart Attack............	yes	no	Thyroid Disease...................	yes	no	Kidney Disease.............	yes	no
AFIB........................	Yes	no	Arthritis....................	yes	no	Cancer, type:__________.	yes	no
Diabetes......................	yes	no	TIA/Stroke................	yes	no	Other:__________________		
Asthma....................	yes	no	HIV/AIDS..............................	Yes	no	____________________		

REVIEW OF SYSTEMS: Have you recently had any:

Fever/chills.....................	Yes	no	Shortness of breath	yes	no	Frequent urination............	yes	no
Unexplained weight loss..	yes	no	Wheezing............................	yes	no	Burning with urination.........	yes	no
Night awakening pain.....	yes	no	Cough......................	yes	no	Irregular heartbeat................	yes	no
Night soaking sweats....	Yes	no	Frequent sore throats.........	yes	no	Chest pain.......................	yes	no
Weakness......................	yes	no	Hearing difficulties.............	yes	no	Fluttering in chest............	yes	no
Sensory loss..................	yes	no	Diarrhea.............................	Yes	no	Easy bruising.....................	yes	no
Loss of Coordination......	yes	no	Bloody stools.......................	yes	no	Acid Reflux.......................	yes	no
Dizziness......................	yes	no	Constipation........................	yes	no	Ulcers.......................	Yes	no

SOCIAL HISTORY:

TOBACCO:______ pk/day QUIT:_______ years ago ALCOHOL:_______/day TATTOOS? Yes No

RECREATIONAL DRUGS:________/day or week HEIGHT:___________ WEIGHT:___________

CURRENT ACTIVITY LEVEL: ______________________________ Assistive device? Yes No

PLEASE LIST MEDICATIONS ON BACK

Total Orthopedic Care

Medication List

Name:______________________________ Date of Birth:______________

Medication list and dosage form:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________
15. ______________________________
16. ______________________________