

Washington Orthopaedic Center Medical History Sheet

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Social History**

Non Contributory

Last

Worked \_\_\_\_\_

Occupation \_\_\_\_\_

Marital Status; M S W D (please circle)

Use of Tobacco Never Previous but quit Current # packs per day: \_\_\_\_\_

Use of Alcohol Never Rarely Moderate Daily Type & Frequency: \_\_\_\_\_

Street Drug Use Never Name of Drug: Last used: \_\_\_\_\_

**Family History** (list Major Health Problems)

Non Contributory

Father: \_\_\_\_\_ Living/Deceased

Mother: \_\_\_\_\_ Living/Deceased

Siblings: \_\_\_\_\_ Living/Deceased

\_\_\_\_\_ Living/Deceased

**Do you have or have you had any of the medical Problems listed Below** (please circle yes or no)

<i>Angina/Chest pain</i>	<i>Y/N</i>	<i>Edema/Swelling</i>	<i>Y/N</i>	<i>Lung Disease</i>	<i>Y/N</i>
<i>Asthma</i>	<i>Y/N</i>	<i>Emphysema</i>	<i>Y/N</i>	<i>Mental Illness</i>	<i>Y/N</i>
<i>Arthritis</i>	<i>Y/N</i>	<i>Fibromyalgia</i>	<i>Y/N</i>	<b>MRSA</b> ( <i>Resistant bacterial infection</i> )	<i>Y/N</i>
<i>Anemia</i>	<i>Y/N</i>	<i>Gout</i>	<i>Y/N</i>	<i>Neurological Problems</i>	<i>Y/N</i>
<i>Alcohol abuse</i>	<i>Y/N</i>	<i>Glaucoma</i>	<i>Y/N</i>	<i>Osteoporosis</i>	<i>Y/N</i>
<i>Bowel Problems</i>	<i>Y/N</i>	<i>Heartburn</i>	<i>Y/N</i>	<i>Problems w/ Surgery</i>	<i>Y/N</i>
<i>Bleeding disorders</i>	<i>Y/N</i>	<i>Heart Attack</i>	<i>Y/N</i>	<i>Seasonal Allergies</i>	<i>Y/N</i>
<i>Bladder Problems</i>	<i>Y/N</i>	<i>High Blood Pressure</i>	<i>Y/N</i>	<i>Skin Disorders</i>	<i>Y/N</i>
<i>Blood Clots</i>	<i>Y/N</i>	<i>High Cholesterol</i>	<i>Y/N</i>	<i>Seizure disorders</i>	<i>Y/N</i>
<i>Cancer (type)</i>	<i>Y/N</i>	<i>Heart Valve Disorder</i>	<i>Y/N</i>	<i>Stroke (when)</i>	<i>Y/N</i>
<i>Cataracts</i>	<i>Y/N</i>	<i>Hepatitis</i>	<i>Y/N</i>	<i>Thyroid</i>	<i>Y/N</i>
<i>Diabetic</i>	<i>Y/N</i>	<i>Immune Disorder</i>	<i>Y/N</i>	<i>Weight Loss</i>	<i>Y/N</i>
<i>Depression</i>	<i>Y/N</i>	<i>Kidney Problems</i>	<i>Y/N</i>	<i>Weight Gain</i>	<i>Y/N</i>
<i>Drug Abuse</i>	<i>Y/N</i>	<i>Liver Disease</i>	<i>Y/N</i>	<i>Other:</i>	<i>Y/N</i>

**Allergies:** (please list all allergies)

None **Allergy to Latex?** Y / N **Allergy to Metal?** Y / N

**Surgeries:** (please list all surgeries and the date)

None



# Washington Orthopaedic Center

## History of Current Injury or Illness

Name : \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ PCP: \_\_\_\_\_

Where is your problem *located*? \_\_\_\_\_  
 When did it happen? (Date of Injury) \_\_\_\_\_  
 How did it happen? \_\_\_\_\_

How *severe* is your problem?      Mild      Mod      Severe      Other: \_\_\_\_\_

Where is your pain?      Front      Back      Side      Other: \_\_\_\_\_

What is your pain *Quality*?      Dull Sore      Sharp Other:      Aching      Stabbing      Throbbing      Shooting

When does it occur?      Constant End of Day      Daily During Activity      In the AM After Activity      At Sleep Occasional

What Makes it Better?      Ice      Heat      Rest      Elevation      Other: \_\_\_\_\_

What Makes it Worse? \_\_\_\_\_

*Associated Symptoms?*      Weak Catching Pain with overhead activity      Numbness Grinding      Tingling Locking      Popping Buckling      Other: \_\_\_\_\_

What Treatment have you tried?      Physical Therapy Surgery Other:      Injections Bracing      Medication

Have you ever injured this before?      Yes      No  
 If Yes Explain: \_\_\_\_\_

Do you have any risk factors, or known, decreased bone mineral density?      Yes      No      Unknown