Washington Orthopaedic Center Medical History Sheet

Name: _____ Date: _____

Social History Non Contributory

Occupation _____ Last Worked _____

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)

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

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

_____

_____

_____

_____

_____

_____

Medication *(please list all medications and vitamins)* 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 Sharp Aching Stabbing Throbbing Shooting
Sore Other: _____

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

What Makes it Better? Ice Heat Rest Elevation Other:

What Makes it Worse? _____

_____

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

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

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