Washington University in St. Louis
SCHOOL OF MEDICINE

ORTHOPEDIC HISTORY

PLEASE USE BLUE OR BLACK INK ONLY

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Height:_____ ft _____ in Weight:_____ lbs

Primary Doctor Name and Address:

_____

_____

Referring Doctor Name and Address:

_____

_____

If not referred, how did you choose this office? _____

Why are you seeing the doctor today?_____

How long has the pain/problem been present?_____

Has the pain/problem worsened recently? ☐ No ☐ Yes, how recently?_____

What started the pain/problem?_____

Quality of the pain ☐ Sharp ☐ Burning ☐ Dull ☐ Aching

How severe is the pain at the location described above?

☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

What makes the pain/problem better?_____

What makes the pain/problem worse?_____

Is the pain (*check all that apply*): ☐ Continuous ☐ Activity related ☐ Night pain ☐ Unpredictable

Did this problem start at work?_____

Have you already filed or will you file a Workers' Compensation claim?_____

Have you missed work because of this problem?_____

What other treatments have you tried?

☐ Physical Therapy/Exercise ☐ TENS unit ☐ Narcotic medications ☐ Cast/boot

☐ Massage/Ultrasound ☐ Traction ☐ Anti-Inflammatories ☐ Orthotics

☐ Manipulation ☐ Surgery ☐ Steroid injections ☐ Braces

Previous physicians seen for <u>this</u> problem

Physician	Specialty	City	Treatment

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ORTHOPEDIC HISTORY

Name of Patient:_____ Date of Birth:_____

Medications taken for <u>this</u> problem

Name of Medication	Dose	Reason

X-Rays and Tests for <u>this</u> problem:

	Results	Date	Location
☐ X-Rays			
☐ MRI			
☐ CT Scan			
☐ Bone Scan			
☐ Other			

Because of this problem, have you filed or do you plan to file a lawsuit? ☐ Yes ☐ No

If you have previously completed a ***Comprehensive Health History*** during a visit to our practice, have there been any changes to your medical history, surgical history or medications since that time? Please describe any changes below:

_____

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient:

Physician Signature:_____ Date:_____

Revised 8/2011

Washington University in St. Louis
SCHOOL OF MEDICINE

COMPREHENSIVE HEALTH HISTORY

PLEASE USE BLUE OR BLACK INK ONLY

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Height:_____ ft _____ in Weight:_____ lbs

Primary Doctor Name and Address:

_____

_____

Preferred Pharmacy (Address/Phone):

_____

_____

MEDICATIONS (prescribed and over the counter): ☐ ***I take no medications***

Name of Medication	Dose	Reason

ALLERGIES (i.e. medications, foods, other) ☐ ***No Allergies***

Name of Allergy	Reaction (rash, swelling, stomach upset, etc.)

METAL ALLERGIES: ☐ ***No Allergies*** ☐ Yes_____ (List Metals)

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COMPREHENSIVE HEALTH HISTORY

Name:_____ Date of Birth:_____

MEDICAL HISTORY: Check all that apply ☐ ***None Apply***

PAST	CURRENT		PAST	CURRENT	
☐	☐	Attention-deficit/hyperactivity (ADD/ADHD)	☐	☐	Hypertension / high blood pressure
☐	☐	Addiction/ alcoholism/substance abuse	☐	☐	Inflammatory bowel disease (ulcerative colitis/ Crohn's)
☐	☐	Anemia (low blood count)	☐	☐	Jaundice
☐	☐	Anxiety	☐	☐	Kidney disease
☐	☐	Arthritis (i.e., osteoarthritis)	☐	☐	Kidney stones
☐	☐	Asthma	☐	☐	Liver Disease
☐	☐	Atrial fibrillation	☐	☐	Meningitis
☐	☐	Bipolar Disorder	☐	☐	Migraines / headaches
☐	☐	Bleeding disorder _____	☐	☐	MRSA infection / colonization
☐	☐	Cancer Type/treatment: _____	☐	☐	Myocardial infarction (MI) (heart attack)
☐	☐	Cerebral palsy	☐	☐	Nerve / muscle disease _____
☐	☐	Congestive heart failure (CHF)	☐	☐	Neurofibromatosis
☐	☐	Cirrhosis of the liver	☐	☐	Neuropathy (peripheral): ☐ Hands / ☐ Feet
☐	☐	Clotting disorder (blood clotting problem)	☐	☐	Obesity
☐	☐	Coombs positive	☐	☐	Osteomyelitis (bone infection)
☐	☐	Deep vein thrombosis (DVT) (blood clot in legs)	☐	☐	Osteoporosis/ osteopenia
☐	☐	Dementia	☐	☐	Pneumonia
☐	☐	Depression	☐	☐	Pulmonary embolism (lung blood clot)
☐	☐	Diabetes: year diagnosed: _____ Currently controlled with ☐ Insulin ☐ Oral medications ☐ Diet	☐	☐	Peripheral vascular disease (PVD)
☐	☐	Diabetic neuropathy: ☐ Hands / ☐ Feet	☐	☐	Raynaud's phenomenon / disease
☐	☐	Down syndrome	☐	☐	Rheumatoid arthritis
☐	☐	Emphysema (COPD)	☐	☐	Seasonal Allergies (allergic rhinitis)
☐	☐	Gastric reflux/ GERD	☐	☐	Seizures
☐	☐	Gout	☐	☐	Sickle cell anemia / trait
☐	☐	Heart murmur	☐	☐	Sleep apnea / obstructive
☐	☐	Heart valve problem	☐	☐	Spina Bifida
☐	☐	Hepatitis (A, B, or C)	☐	☐	Spinal Cord Injury
☐	☐	Hiatal hernia	☐	☐	Stroke (CVA)
☐	☐	HIV/AIDS	☐	☐	Thyroid disease
☐	☐	Hypercholesterolemia (high cholesterol)	☐	☐	Tuberculosis
			☐	☐	Ulcers (GI)
			☐	☐	Urinary tract infection (UTI / bladder infection)

☐ Other: _____

_____

_____

Name:_____ Date of Birth:_____

PAST SURGICAL HISTORY: ☐ ***No Prior Surgery***

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? ☐ No ☐ Yes
If YES, have you had any problems related to this? ☐ No ☐ Yes
Please explain any problems related to general anesthesia: _____

_____

SOCIAL HISTORY:

Work status:

☐ Working ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ On leave ☐ Retired ☐ Student

Occupation_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children ☐ No ☐ Yes, How Many?_____

Do you live alone?_____ If no, who lives with you?_____

Are you currently smoking?_____ If yes, how many packs a day?_____ For how many years?_____

Have you quit smoking? If so, when did you quit?_____ How many years did you smoke?_____

How many packs a day did you previously smoke?_____Other forms of tobacco?_____

Alcohol Use ☐ Never ☐ Rare ☐ Social ☐ Frequently (more than twice a week)
☐ Alcoholic ☐ Recovering Alcoholic

Illegal Drug Use ☐ Never ☐ In the past ☐ Currently Types of Drugs_____

Name:_____ Date of Birth:_____

FAMILY HISTORY: Check all that apply ☐ ***None apply***

	Father	Mother	Brother	Sister	Son	Daughter	Other (Grandparent, etc) (Specify)_____
Heart Disease							
Scoliosis							
Kyphosis							
Spondylolisthesis							
Arthritis							
Seizure							
Bleeding Problems							
High Blood Pressure							
Stroke							
Gout							
Alcoholism							
Cancer							
Blood Clots							
Kidney Problems							
Diabetes							
Lung Problems							
Mental Illness							
Other _____							

Other Family History:_____

_____

_____

Name:_____ Date of Birth:_____

REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?)

Constitution
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Malaise/Fatigue
- ☐ Diaphoresis (excessive sweating)
- ☐ Weakness

Skin
- ☐ Rash
- ☐ Itching

Head/Ear/Nose/Throat (ENT)
- ☐ Hearing loss
- ☐ Tinnitus (ringing in ears)
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Sinus pain
- ☐ Stridor (noisy breathing)
- ☐ Sore throat

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Photophobia (light sensitivity)
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Orthopnea (shortness of breath when lying down)
- ☐ Claudication (pain or cramping in legs)
- ☐ Leg swelling
- ☐ Paroxysmal nocturnal dyspnea (PND, shortness of breath/coughing at night)

Respiratory
- ☐ Cough
- ☐ Hemoptysis (coughing up blood)
- ☐ Sputum production (coughing up mucus/phlegm)
- ☐ Shortness of breath
- ☐ Wheezing

GI
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Melena (dark/black stool)

Genitourinary (GU)
- ☐ Dysuria (pain, burning, or discomfort upon urination)
- ☐ Urgency
- ☐ Frequency
- ☐ Hematuria (pink, red or cola-colored urine)
- ☐ Flank pain

Musculoskeletal
- ☐ Myalgias (muscle pain)
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint swelling
- ☐ Falls

Endocrine/Hematology/Allergy
- ☐ Easy bruise/bleed
- ☐ Environmental allergies
- ☐ Polydipsia (excessive thirst)

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech change
- ☐ Focal weakness
- ☐ Seizures
- ☐ Loss of consciousness (LOC)

Behavioral
- ☐ Depression
- ☐ Suicidal ideas
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Nervous/anxious
- ☐ Insomnia
- ☐ Memory loss

☐ ***I have not experienced any of the above symptoms in the last 30 days***

☐ Other:_____

_____

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient/family:

Physician Signature:_____ Date: _____