History & Physical

Name:_____ Date:_____

Date of Injury:_____ Occupation:_____

Referring Doctor:_____ Height:_____ Weight;_____ Age:_____

What are we seeing you for?_____ Side: R / L

Details of injury (How? Where? What happened?):_____

_____

MEDICATIONS **DOSAGE** **TIMES/DAY**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

Member	Alive/Dead		
Grandma (mom'	A / D		Health Status
Grandpa (mom's	A / D		
Grandma (dad's	A / D		
Grandpa (dad's)	A / D		
Dad	A / D		
Mom	A / D		
Siblings	A / D		
Siblings	A / D		
Siblin	A / D		
Siblings	A / D		

HOSPITALIZATIONS/SURGERIES **COMPLICATIONS** **YEAR**

_____

_____

_____

_____

Have you ever had general anesthesia? Y / N List problems if any:_____

DRUG ALLERGIES **REACTION**

_____

_____

SOCIAL HISTORY

Marital Status: Single Married Divorced Widow(ed) **Do you live alone?** Y / N

Do you exercise regularly? Times/week_____ Type of exercise:_____

Do you smoke? Y / N Packs per day_____ How many years?_____

Do you use alcohol? Y / N Drinks per day _____

Do you use drugs? Y / N What?_____ How long?_____ Drug Rehab? Y / N

PAST MEDICAL HISTORY (Problem Diagnosis History)

Please check any of the following health problems with which you have been diagnosed:

___ Alcoholism
___ Anemia
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Blood Clots
___ Cancer of _____
___ Drug Dependency
___ Chest Pain
___ Coronary Artery Disease
___ Depression
___ Diabetes
___ Emphysema/COPD
___ Epilepsy
___ Gastris Reflux Disease
___ Gout
___ Hepatitis
___ HIV/AIDS
___ High Cholesterol
___ Hypertension
___ Irregular Heartbeats
___ Kidney Stones
___ Numbness/Tingling
___ Osteoporosis
___ Pacemaker
___ Prostate Problems
___ Seizures
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___ Ulcers
___ Vascular Disease
___ Other_____

Patient Signature_____

HEART_____ IMP:

CHEST_____ PLAN: Physician Signature:_____

ABDOMEN_____

Orthopaedic Associates, LLP

Review of Systems

REVIEW OF SYSTEMS: Please check if you are currently having any of the following:

CONSTITUTIONAL
- ☐ night sweats
- ☐ recent illness
- ☐ fever

EYES
- ☐ vision change
- ☐ blurred vision
- ☐ macular degeneration

EARS, NOSE, THROAT
- ☐ dizziness
- ☐ sleep apnea-obstruction

CARDIOVASCULAR
- ☐ chest pain/pressure
- ☐ high blood pressure
- ☐ short of breath
- ☐ swelling in legs

LUNGS, BREATHING
- ☐ asthma
- ☐ cough

GASTROINTESTINAL
- ☐ diarrhea
- ☐ nausea

GENITOURINARY/NEPHROLOGY
- ☐ urinary frequency
- ☐ urinary incontinence

MUSCULOSKELETAL
- ☐ stiffness
- ☐ swelling
- ☐ joint pain(s)
- ☐ back pain

DERMATOLOGIC
- ☐ food allergy
- ☐ rashes
- ☐ lesions

NEUROLOGIC
- ☐ neck pain
- ☐ numbness
- ☐ seizure
- ☐ spasms/spasticity

PSYCHIATRIC
- ☐ alcohol abuse
- ☐ drug abuse

ENDOCRINE
- ☐ diabetes type I
- ☐ diabtetes type II

HEMATOLOGIC/LYMPHATIC
- ☐ abnormal bleeding and bruising
- ☐ anemia

ALLERGY/IMMUNOLOGY
- ☐ anaphylactoid reaction

_____

Patient Signature Date