

**Orthopaedic History**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

S.S.# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**CHIEF COMPLAINT**

Why are you seeing the doctor today? \_\_\_\_\_

Your current problem is the result of a(n): (check all that apply)

Car accident     Work accident     Accident     Other

Medication	Dose	Reason for Medication	Side Effects

Allergies: \_\_\_\_\_

Are all your immunizations up to date?     Yes     No

If no, which immunizations are due? \_\_\_\_\_

**REVIEW OF SYSTEMS**

Are you currently having or have you had problems with your:

	Circle		Describe all "Yes" responses
Eyes	NO	YES	_____
Ears, nose, throat	NO	YES	_____
Lungs, breathing	NO	YES	_____
Digestion	NO	YES	_____
Bowel movement	NO	YES	_____
Bladder problems	NO	YES	_____
Diabetes	NO	YES	_____
High blood pressure	NO	YES	_____
Bleeding problems	NO	YES	_____
Balance problems	NO	YES	_____
Numbness/tingling	NO	YES	_____
Blackout/fainting	NO	YES	_____

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**MILLER SCHOOL OF MEDICINE – UNIVERSITY OF MIAMI**  
**ORTHOPAEDICS AND REHABILITATION - CEDARS**  
Miami, FL 33136                      (305) 585-7275

**ORTHOPAEDIC HISTORY**

NAME: \_\_\_\_\_

MRN: \_\_\_\_\_

AGE: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DATE OF SERVICE: \_\_\_\_\_



Form  
H0700008

Revised  
10/10/05

## Orthopaedic History

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Hepatitis	NO	YES	
Psychological problems	NO	YES	
HIV/AIDS	NO	YES	
Cancer	NO	YES	
Arthritis	NO	YES	
Polio	NO	YES	
TB	NO	YES	
Epilepsy	NO	YES	

### PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia?     Yes     No

Have you had problems with the anesthesia?     Yes     No    Describe: \_\_\_\_\_

### FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status/Cause of Death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

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## SOCIAL HISTORY

Retired     Student     Employed (occupation) \_\_\_\_\_  Work in the home

Single     Married     Divorced     Separated     Widowed

Children?     No     Yes # \_\_\_\_\_

Do you live alone?     No     Yes

Exercise?     Daily     Weekly     Monthly     Rarely     Never

What type of exercise? \_\_\_\_\_

History of substance abuse?     No     Yes     What? \_\_\_\_\_

Smoke currently?     No     Yes    \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Quit smoking?     This year     > 1 year     > 5 years     > 10 years

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

## REFERRING PHYSICIANS

PCP: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

## SPECIALISTS

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

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