MEDICAL-ORTHOPAEDIC HISTORY

Fayetteville Orthopaedics & SPORTS MEDICINE

Date of Injury / Onset of Symptoms _____

Name of patient _____ Age _____ Male _____ Female _____

Why are you here today? _____

Who referred you to us? _____

Have you ever been hospitalized? _____

Past Medical History

Have you had any medical problems?	None ❒	
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Obstructive Pulmonary Disease	Yes	No
Kidney Disease	Yes	No
Thyroid Disease	Yes	No
AIDS/HIV	Yes	No
Hepatitis	Yes	No
Rheumatoid Arthritis	Yes	No

Please list any medications you are currently taking, including dietary supplements:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Surgical History

Please list any operations you have had: None ❒

_____
_____
_____

Allergies

List all drugs to which you are allergic: None ❒

_____
_____
_____

Review of Systems

Do you have any of these symptoms? Please circle Yes or No for each condition:

Constitutional		
Depression	Yes	No
Fever	Yes	No
Weight Loss/Gain	Yes	No
Heart		
Chest Pain	Yes	No
Irregular Heart Beat	Yes	No
Poor Circulation	Yes	No
Genitourinary		
Bloody Urine	Yes	No
Pain on Urinating	Yes	No
Unable to Urinate	Yes	No
Neurological		
Paralysis	Yes	No
Frequent Headaches	Yes	No
Blood		
Bleeding Problems	Yes	No
Previous Blood Transfusions	Yes	No

Eyes		
Decreased Vision	Yes	No
Cataracts	Yes	No
Lungs		
Shortness of Breath	Yes	No
Wheezing	Yes	No
Persistent Cough	Yes	No
Musculoskeletal		
Joint Swelling	Yes	No
Muscle Aches	Yes	No
Joint Pain	Yes	No
Psychiatric		
Depression	Yes	No
Bipolar Disease	Yes	No
Allergic		
Allergies to Food	Yes	No
Allergies to things other than Medicines	Yes	No

Ear - Nose - Throat		
Loss of Hearing	Yes	No
Sinus Problems	Yes	No
Gastrointestinal		
Stomach Pain	Yes	No
Diarrhea	Yes	No
Persistent Vomiting	Yes	No
Skin		
Rash	Yes	No
Dryness of Skin	Yes	No
Endocrine		
Thyroid Problems	Yes	No
Diabetes	Yes	No
Other		

_____
_____
_____

Are you currently being treated for these conditions? Yes No

Social History

Do you use the following?

Tobacco Yes No

Alcohol Yes No

Do you have or have you had a problem with chemical dependency? Yes No

Are you pregnant? Yes No