

ORTHOPAEDIC HISTORY FORM

Name: _____ Email: _____ Date: _____

SSN: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Pulse: _____ Male Female

CHIEF COMPLAINT: _____

How long have you had this problem? _____

Current problem is the result of (check all that apply): Car Accident Work Accident Accident Other

_____ If accident, please describe. Give exact date and location: _____

Do you have an attorney or do you plan to contact an attorney regarding this injury? Yes No

PAST MEDICAL HISTORY AND CURRENT MEDICAL CONDITION

Surgeries	Year	Complications	Past/Present Medical Problems

Have you ever had general anesthesia? Yes No Have you had problems with anesthesia? Yes No

If yes, please describe: _____

ALLERGIES/DRUG REACTIONS

Allergies to Medications	Type of Problem	Allergies to Medications	Type of Problem

CURRENT MEDICATIONS (Prescription, Over-the-counter, Herbal Supplements)

Medication	Dosage (100mg, 1 tablet, etc.)	Frequency (one daily, etc.)	Medication	Dosage (100mg, 1 tablet, etc.)	Frequency (one daily, etc.)

M.D. Initials/Date: _____

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