ORTHOSURGERY
Ιατρείο Ορθοπαιδικών Παθήσεων

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Health History Questionnaire

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Patient's name:_____

DOB: _____

Primary Care Physician: _____ Today's date:

Past Medical History: Check any illnesses you may have or have had in the past.

☐**NONE** ☐Blood Clots ☐Osteoporosis

☐Gastric Ulcer ☐High Blood Pressure ☐Heart Attack

☐HIV ☐Diabetes ☐Stroke

☐Rheumatoid Arthritis ☐Osteoarthritis ☐ Bleeding Disorder

☐Cancer: specify

_____

☐Hepatitis: specify

_____

☐Other:

_____

Past Surgical History: Check any surgeries that you have already had.

☐**NONE** ☐Appendectomy ☐Gall Bladder ☐Vascular bypass

☐Heart Surgery ☐Hysterectomy ☐ Tonsillectomy

☐Total joint replacement: specify

_____

☐Back Surgery: specify

_____

☐Fracture Repair: specify

_____

☐

Other:_____

Medications: Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, and heart medications.

☐**NONE**

Name	Strength	Frequency	Name	Strength	Frequency

Allergies: Check all that apply.

☐**NO KNOWN DRUG ALLEGIES** ☐Anesthetic ☐Penicillin ☐Iodine

☐Demerol ☐Aspirin ☐ Codeine ☐Sulfa

☐Morphine

☐Other: _____

Patient: _____ Height: _____ Weight: _____

Social History: Please check. ☐Married ☐ Widowed ☐ Divorced ☐ Single

Do you smoke? ☐ yes ☐no Packs/Day: _____ Number of years you have smoked: _____

Do you drink alcohol? ☐yes ☐no Drinks/Week: _____

Occupation: _____

Family History: Please check all that have significance in your family's history, not your own history.

☐**NONE**

Father has ☐Arthritis, ☐Diabetes, ☐Heart disease, ☐Stroke , ☐Cancer. ☐Deceased .

Other:_____

Mother has ☐Arthritis, ☐Diabetes, ☐Heart disease, ☐Stroke , ☐Cancer. ☐Deceased .

Other:_____

Siblings have ☐Arthritis, ☐Diabetes, ☐Heart disease, ☐Stroke , ☐Cancer. ☐Deceased .

Other:_____

List family history of orthopedic problems:

_____

Other: _____

Review of systems: Circle all symptoms that apply to you from each of the 14 categories.

1. Constitutional	Night sweats	Fever/chills	NONE
	Unexpected weight loss/gain	Lbs in the last year?	
2. Eyes	Visual changes	Glasses or Contacts	NONE
3. Ears, nose, throat	Hearing problems	Sore throat	NONE
	Cold	Sinus allergies	
4. Cardiovascular	Chest Pain	Palpitations	NONE
	Leg swelling	Calf cramps with walking	
5. Respiratory	Shortness of breath	Wheezing	NONE
	Frequent cough	Coughing up blood	
6. Gastrointestinal	Ulcer	Bowel/bladder control problems	NONE
	Diarrhea	Vomiting	
7. Genitourinary	Incontinence	Burning while urinating	NONE
	Blood in urine	Kidney stones	
8. Musculoskeletal	Back ache	Joint stiffness	NONE
	Joint swelling	Joint pain	
9. Integumentary	Rash	Hair problem	NONE
	Nail problem		
10. Neurological	Headaches	Memory loss	NONE
	Fainting	Tingling and numbness	
11. Psychiatric	Depression	Nervousness	NONE
	Personality change	Previous psychiatric care	
12. Endocrine	Excessive urination	Excessive thirst	NONE
	Intolerance to heat/cold		
13. Hematologic/ Lymphatic	Abnormal bleeding	Anemia	NONE
14. Allergic/Immunologic	Immunization problems	Allergy shots	NONE

Problem Questionnaire

Patient: _____ Today's date:_____

Which body part is involved? _____ ☐left ☐right ☐ both

Check any symptoms that you are having ☐pain ☐swelling ☐weakness ☐instability ☐numbness

☐Describe any others_____

When did it begin? _____ Rate your pain on a scale of 1 – 10, 10 being the worst :_____

Was it caused by an injury? ☐yes ☐no Was the injury job related? ☐yes ☐no

Describe the accident: (if applicable):_____
_____
_____

How did it begin? ☐gradually ☐suddenly Is the condition ☐intermittent or ☐ constant?

What makes the condition worse?
_____
_____
_____

What makes the condition better?
_____
_____
_____

Have you had a similar problem in the past? ☐yes ☐no. If yes, describe:_____
_____
_____

Have you seen another health care provider for this problem? ☐yes ☐no

Doctor:
_____
_____

What specific treatment have you had?

☐**NONE**
☐brace
☐cast
☐cortisone injection
☐narcotic medication (Vicodin, Lortab)
☐arthritis medication (Advil, Aleve)
☐physical therapy
☐shoe modification
☐x-rays
☐wooden soled shoe
☐orthotics/insoles
☐ice or heat therapy
☐crutches
☐MRI
☐other – describe:_____

_What specific things does your condition prevent you from doing?