

ROME ORTHOPAEDIC CLINIC PATIENT HISTORY

Please complete FRONT AND BACK

Name: _____ Today's Date: ____/____/____
Date of Birth: ____/____/____ Age: _____ Referred by: _____
Employed by: _____ Right or Left Handed: R L
Job Description: _____
Height: _____ Weight: _____

HISTORY OF PRESENT PROBLEM

Why are you seeing the doctor today? _____
This problem is the result of:(circle all that apply) Car Accident Work Accident Accident Other
Date of Accident: ____/____/____ Location where accident occurred: _____
Where is the pain/problem? _____
How long have you had the pain/problem? _____
Is pain dull, throbbing, sharp, constant? _____
Any bruising, numbness, tingling, other symptoms? _____

MEDICATIONS

List all medications including non-prescription meds which you are taking:

Medication Allergies: _____

Date of last Tetanus shot? _____

Are you taking any hormone replacement drugs or oral contraceptives? ____yes ____no

REVIEW OF SYSTEMS

Note any problems that you are currently having or have had problems with:

Please describe all Yes Responses

Lungs/Breathing	No	Yes	_____
Digestion(Reflux,Heartburn,Ulcer)	No	Yes	_____
Constipation/Blood in Stool	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance/Coordination Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____

AIDS/Hepatitis	No	Yes	_____
Joint Pain/Stiffness/Swelling	No	Yes	_____
Muscle Pain or Weakness	No	Yes	_____
Heart Disease/Short of Breath	No	Yes	_____

FAMILY HISTORY

List any siblings, parents, or grandparents who have had any of the above problems:

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a blood clot, deep venous thrombosis, or pulmonary embolus? No Yes

Have you ever had general anesthesia? No Yes

If yes, did you have any problems with anesthesia? No Yes Describe: _____

SOCIAL HISTORY

Current Marital Status: Single Married Divorced Widowed

Children: No Yes (#) _____

Do you live alone? No Yes

Tobacco Use: No Yes (# of packs/day) _____

Previous Tobacco Use: No Yes (# of years) _____ Year Stopped _____

Alcohol Use: Never Occasionally _____ Weekly _____ Daily

Illegal Drug Use: Never Type/ Frequency _____

FEMALES ONLY:

Date of last menstrual period: ___/___/___ Are you, or could you be pregnant? No Yes

To the best of my knowledge, questions in this form have been answered accurately. I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform necessary services that I may need.

Patient Signature: _____ **Date:** ___/___/___

Reviewed By: _____ **Date:** ___/___/___