

# ROME ORTHOPAEDIC CLINIC PATIENT HISTORY

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? \_\_\_\_\_

## 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 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:** \_\_\_/\_\_\_/\_\_\_