



Orthopaedic Associates, P.S.C.

COMPREHENSIVE HISTORY: ADULT PATIENT

Today's Date _____

Name _____

Age _____ Date of Birth _____ Sex _____ Race _____

Place of Birth _____

Marital Status _____ Occupation _____

Who referred you here?

Chief Complaints *What problem do you need to discuss with the doctor*

Past Medical History

General state of health excellent, good, fair, poor (circle one)

Childhood illnesses: measles, German measles, mumps, whooping cough, chicken pox, rheumatic fever, scarlet fever, polio (*circle those you have had*)

Psychiatric illnesses

Immunizations tetanus - year of last shot _____, pertussis, diphtheria, polio, measles, German measles, mumps (*circle those shots you have had*)

Operations

problem	date	hospital	physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Fractures (broken bones)

bone	date	physician	outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Diet excellent, good, fair, poor (circle one)

Sleep excellent, good, fair, poor (circle one)

Exercise regular, sometimes, rarely, (circle one) type _____

use of coffee _____ cups per day

alcohol how often _____ type _____ how much _____

other drugs Type _____

tobacco Type _____ how much _____ for how long _____ years

Family History

	age	current health or cause of death
mother	_____	_____
father	_____	_____
spouse	_____	_____
child	_____	_____
child	_____	_____
child	_____	_____
child	_____	_____

*The occurrence within the family of any of the following conditions (please circle all that apply):
diabetes, tuberculosis, heart disease, high blood pressure, stroke kidney disease, cancer, arthritis,
anemia, headaches, mental illness, or symptoms like those of the patient.*

Background History

schooling; grade completed _____

military service _____

job history _____

marriage _____

retirement _____

Review of Systems (circle all that apply)

General: usual weight _____, recent weight loss, recent weight gain, weakness, fatigue, fever

Skin: rashes, lumps, itching, dryness, color change, changes in hair or nails

Head: headache, head injury

Eyes: vision, glasses or contact lenses, last eye examination _____, pain, redness, excessive tearing, double vision, glaucoma, cataracts

Ears: hearing, ringing in the ears, vertigo, earaches, infection, discharge

Nose and sinuses: frequent colds, nasal stuffiness, hay fever, nosebleeds, sinus trouble

Mouth and throat: change in the condition of teeth and gums, bleeding gums, sore tongue, hoarseness, frequent sore throats, last dental examination

Neck: lumps in neck, "swollen glands," goiter, pain in the neck

Breasts: lumps, pain, nipple discharge, self-examination (circle): regularly, irregularly, never

Respiratory: cough, excessive sputum, bloody sputum, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy, tuberculin test date _____, last chest X-ray date _____

Cardiac: heart trouble, high blood pressure, rheumatic fever, heart murmurs, shortness of breath, number of pillows used at night _____, edema,; chest pain, palpitations; past electrocardiogram or other heart tests _____(when and where)

Gastrointestinal: trouble swallowing, heartburn, appetite, nausea, vomiting, vomiting of blood, indigestion, frequency of bowel movements _____, change in bowel habits, rectal bleeding or back tarry stools, constipation, diarrhea; abdominal pain, food intolerance, excessive belching or passing of gas, hemorrhoids, jaundice, liver or gall bladder trouble, hepatitis

Urinary: frequency of urination, bloody urine, painful urination, how many times do you get up to urinate at night_____, urgency, hesitancy, incontinence, urinary infections, stones

Genito-reproductive:

Male: discharge from or sores on penis, history of venereal disease, hernias, testicular pain or masses, sexual difficulties

Female: age when periods started _____, date of last period _____, bleeding between periods or after intercourse, painful periods, age at menopause _____, menopausal symptoms, post-menopausal bleeding, discharge, itching, venereal disease, last Pap smear date _____. Number of pregnancies _____, number of deliveries _____, number of abortions _____, complications of pregnancy _____, birth control methods _____, sexual difficulties.

Musculoskeletal: joint pains or stiffness, arthritis, gout, backache. Muscle pains or cramps.

Peripheral vascular: cramping in the legs when walking, cramps, varicose veins, blood clots

Neurological: fainting, blackouts, seizures, paralysis, local weakness, numbness, tingling, tremors, memory problems

Psychiatric: nervousness, tension, mood swings, depression

Endocrine: thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst, excessive hunger, excessive urination

Hematologic: anemia, easy bruising or bleeding, past transfusions and/ or possible reactions to blood products

Infectious diseases: TB, hepatitis, HIV, AIDS, staph infections

I have answered this form truthfully and to the best of my ability

Signature _____