Dr. Terrence L. Piper | Dr. Christopher R. Hemmer
Dr. Theodore S. Rummel

ORTHOPEDIC HISTORY

Name: _____ Height/Weight: _____ Birthdate: _____ Pharmacy: _____

Primary Care Physician: _____ Referring Physician: _____

_____

History of Current Problem

Describe Problem: _____
When did the problem start? _____ How did the problem start? _____
Current problem is the result of a (check all that apply):
□ Car Accident □ Work Accident □Chronic □ Other: _____
What tests have you had for this problem? □ XRay □ MRI □ Other: _____
What treatments have you had for this problem? _____
What type of work do you do? _____
What is your Work Status? □ Full Time □ Part Time □ Unemployed □ Disabled □ Retired

Pain Rating

Are you experiencing pain? □ YES □ NO Describe the pain: _____

Please circle the number that represents the amount of pain you are having

(No Pain)	0	1	2	3	4	5	6	7	8	9	10	(Worst Pain of Your Life)

Does it disturb your sleep? □ YES □ NO
What makes it feel better? _____ Worse? _____
What are you now unable to do because of this condition? _____

Past Medical History

Condition	Y	N	Condition	Y	N
Sleep Apnea			Diabetes?		
Reflux			Last HbA1c Value? _____		
Taking blood thinner medication?			Anesthetic difficulties?		
High Blood Pressure?			Cancer?		
Coronary artery disease?			Rheumatoid arthritis?		
Congestive Heart Failure?			Blood Clot/ Pulmonary Embolism?		
Asthma?			Osteoporosis?		
COPD?			Gout?		
Hepatitis C?			Kidney disorders?		
HIV?			High Cholesterol?		
Other: _____					

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Current Medications (Name and Dose):

_____
_____
_____
_____

Allergies (Name and Type of Reaction):

_____
_____

Past Surgical History:

_____
_____
_____

Family History:

Cancer	□YES	□NO
Heart Disease	□YES	□NO
Hypertension	□YES	□NO
Osteoarthritis	□YES	□NO

Other: _____

Social History:

Alcohol Use	□YES	□NO	drinks/week: _____
Smoking	□YES	□NO	packs/day: _____
Drug Use	□YES	□NO	

Review of Systems:

Systemic Symptoms	Y	N	Pulmonary Symptoms	Y	N
• Weight Change			• Shortness of Breath		
• Chills/Fever			• Cough		
• Night Sweats			• Coughing up Blood		
• Feeling Tired or poorly			• Wheezing		
HEENT Symptoms			Cardiovascular Symptoms		
• Headache			• Chest pain or discomfort		
• Eyesight Problems			• Fast heart rate		
• Nosebleed			• Palpitations		
Genitourinary Symptoms			Gastrointestinal Symptoms		
• Blood in Urine			• Difficulty Swallowing		
• Painful Urination			• Heartburn		
• Increased Urinary Frequency			• Vomiting		
Skin Symptoms			• Abdominal Pain		
• Skin infections			• Diarrhea		
• Skin lesions			Hematological Symptoms		
• Rashes			• Easy bleeding		
Endocrine Symptoms			• Easy bruising tendency		
• Excessive sweating			• Blood clots/Pulmonary Embolism		
• Excessive Thirst			Neurological Symptoms		
• Sleep disturbances			• Dizziness		
Psychological Symptoms			• Vertigo		
• Sleep Disturbances			• Loss of strength		
• Anxiety			• Sensory disturbances		
• Depression			Other _____		

Patient Signature: _____ Date: _____

Physician Signature: _____

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