Grand River Medical Center
Orthopaedic Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date: _____ **Date of Last Physical Exam:** _____

Last Name: _____ **First Name:** _____ **MI:** _____

Social Security No: _____ **Date of Birth:** _____

Chief Complaint

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

Height: _____ **Weight:** _____

History of Present Illness

Please answer the following questions

Location of the problem

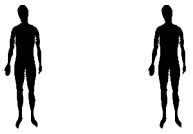
Abdomen Back Leg

Other: _____

_____

_____

Front **Back**



On a scale of 1-10 with 10 being the most severe, circle the Number that best describes the problem.

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other: _____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other: _____

How long does the problem last?

30 minutes 1 hour It is always there

Other: _____

Is anything else occurring at the same time?

Yes No If yes, please explain

Nausea Rash Headaches

Other: _____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Other: _____

Does the problem interfere with your normal functions?

Yes No Other: _____

Physician Use Only: (Comments/Notes)	# Answer	Level of Service
	1 – 3	1 or 2
	4+	3 - 5

Past Medical and Social History

List all serious illnesses in your immediate family. (Example: Diabetes, Tuberculosis, Breast Cancer, Heart Disease, etc.)

_____ _____ _____

_____ _____ _____

List any personal past illness and/or surgeries And when they occurred.

Illness or Surgery **Date**

_____

_____

Do you smoke: Yes No (If yes, how much)

_____

Do you drink? Yes No (If yes, how much)

_____

Are you on any medications? Yes No (If yes, list all)

_____ _____

_____ _____

Are you on a special diet? Yes No (If yes, please explain)

_____

Do you have allergies? Yes No (If yes, please explain)

_____

_____

Physician Use Only: (Comments/Notes)	#Answer	Level of Service
	0	1 or 2
	1 – 2	3
	3	4 or 5

Patient Name: _____

Review of Systems

Do you now or have you had any problems related to the following systems? **Circle YES or NO.**
Please explain any **YES** answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other: _____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Other: _____

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other: _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other: _____

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N

Other: _____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N

Other: _____

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other: _____

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other: _____

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other: _____

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other: _____

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Other: _____

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Other: _____

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Prob	Y	N

Other: _____

Psychological

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other: _____

Physician Use Only: (Comments/Notes)

#Answer	Level of Service
0 –1	1 or 2
2 – 9	3

Physician: _____ **Date:** _____