IMPACT ORTHOPAEDICS

Medical and Social History

Today's Date_____ HT: _____ WT: _____

Patient Name_____ DOB _____ AGE _____
Last First

Date of Injury: _____

Main reason for this visit_____

_____

_____

_____

Referred By _____Primary Doctor_____

Did you previously receive treatment for your current problem from another physician?

☐ Yes Physician Name_____
☐ No

Did you have X-rays taken elsewhere? ☐ Yes ☐ No

General Personal History – Please indicate whether you have ever had one of the following:

☐ Hypertension (high blood pressure)	☐ Asthma	☐ Blood clots (DVT)
☐ Heart failure (CHF)	☐ Stroke (CVA)	☐ Kidney failure
☐ Diabetes mellitus - *Insulin dependent _____ *Non-insulin dependent _____		
☐ Fractures	☐ Heart attack (If yes, indicate year) _____	
☐ Heart failure (CHF)		
☐ Stomach ulcer – Bleeding? ☐ Yes ☐ No		
☐ Transfusion reaction (blood products)		
☐ Cancer (please specify) _____		
☐ I have never had any of the above conditions.		

Medical and Social History

Surgical History: List any surgeries and related information below:

Type of Surgery	Date of Surgery	Surgeon / Hospital

Have you ever had problems with anesthesia? ☐ **No** ☐ **Yes**
Describe_____

Family History: Please indicate if any direct relative has had one of the following:

Disease/Condition/Disorder	Please Explain
Diabetes mellitus	
Rheumatoid arthritis	
Hypertension	
Heart disease/disorder	
Cancer	
Other	

Review of Systems: Please check all that apply to you:

General	☐ Fatigue	☐ Unexplained weight loss or gain, not related to diet	☐ Fever
Skin	☐ Jaundiced	☐ Bruising	☐ Rash / ulcers
Musculoskeletal	☐ Stiffness ☐ Weakness	☐ Joint pain ☐ Impaired range of motion ☐ Fibromyalgia / myofascial pain	☐ Swelling ☐ Same orthopaedic problem in the past
Respiratory	☐ Tuberculosis	☐ Shortness of breath	☐ Chronic cough
Cardiovascular	☐ Blood clots	☐ Chest pain	☐ Palpitations
Gastrointestinal	☐ Blood in stool ☐ Change in bowel habits	☐ Heartburn / ulcers ☐ Nausea / vomiting	☐ Stomachache caused by anti-inflammatory medications
Neurological	☐ Tingling ☐ Numbness	☐ Headaches ☐ Seizures	☐ Sensory deficit
Psychiatric	☐ Anxiety / nervousness	☐ Depression	☐ Insomnia
Endocrine	☐ Heat / cold intolerance	☐ Thyroid disease	
Hematology	☐ Blood disorders	☐ Anemia	☐ Easy brusing / bleeding
Cancer	☐ Specify type_____		

IMPACT ORTHOPAEDICS

Medical and Social History

Medication Information:

List the medications you are currently taking and the dosage. Include prescription and non-prescription medications.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergy Information:

Are you allergic to any medications? ☐ Yes ☐ No Are you allergic to latex? ☐ Yes ☐ No

☐ Yes – Please list below and indicate your reaction.

_____ _____ _____

_____ _____ _____

Social History:

Occupation: _____ Employer: _____
Maritial Status: _____
Do you use tobacco products? ☐ Yes or ☐ No If yes, packs per day_____
Do you drink alcohol? ☐ Yes or ☐ No If yes, amount and frequency_____
Are you currently pregnant? ☐ Yes or ☐ No *(Information needed for X-Ray purposes)*

The information on this form is accurate to the best of my knowledge.

Signature_____Date_____