Northern Rockies Orthopaedics

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Comprehensive History

Date: _____

Name: _____ **Age:** _____ ❑ Male ❑ Female

Do you have a cardiologist? No or Yes: _____

Name of your primary care physician: _____

Review of Systems: (Check any of the following that you've had in the last 12 months)

❑ Weight loss	❑ Chest pain	❑ Muscle weakness
❑ Weight gain	❑ Irregular heart beat	❑ Rashes
❑ Fatigue	❑ Shortness of breath	❑ Sores
❑ Blurry vision	❑ Trouble breathing	❑ Numbness
❑ Double vision	❑ Cough	❑ Poor balance
❑ Ringing in ears	❑ Upset stomach	❑ Anxiety
❑ Hearing loss	❑ Diarrhea	❑ Depression
❑ Sinus congestion	❑ Bloody stools	❑ Hair loss
❑ Bloody nose	❑ Frequent Urination	❑ Excessive thirst
❑ Loss of taste	❑ Burning with urination	❑ Easy bruising
❑ Dry mouth	❑ Joint pain	❑ Food allergies
❑ Sore throat	❑ Joint stiffness	❑ Seasonal allergies

❑ **NONE OF THE ABOVE**

PAST MEDICAL HISTORY:

(Circle yes or no)

Ulcers	Yes or No
Diabetes (I or II)	Yes or No
Hearing device	Yes or No
Heart disease	Yes or No
Circulation problems	Yes or No
High blood pressure	Yes or No
Cancer	Yes or No
Lung disease	Yes or No
Hepatitis	Yes or No
HIV	Yes or No
Sleep apnea	Yes or No

Other: _____

Previous Surgery: ❑ NONE

_____

_____

_____

Medication Allergies: ❑ NONE KNOWN

_____

_____

_____

Medications – List dose and frequency

(Include over-the-counter and holistic medicines)

❑ **NONE** ❑ **SEE ATTACHED LIST**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

✵ **TURN OVER TO COMPLETE** ✵

Family History: ❑ Adopted, family history unknown

Does anyone in your family have:		
	High blood pressure	Yes or No
	Diabetes	Yes or No
	Heart disease	Yes or No
	Stroke	Yes or No
	Cancer	Yes or No

Is your Father: Living or Deceased Cause of death: _____

Is your Mother: Living or Deceased Cause of death: _____

Number of brothers: _____ Number deceased: _____ Cause of death: _____

Number of sisters: _____ Number deceased: _____ Cause of death: _____

Social History:

Marital Status: Single Married Divorced Widowed

Live alone? Yes No

Occupation: _____

Do you smoke? Yes No Packs per day: _____

How many years? _____

Do you drink alcohol? Yes No How much/often? _____

Patient/Guardian signature: _____ **Date:** _____

Reviewed by: _____MD Date: _____

_____MD Date: _____

_____MD Date: _____

_____MD Date: _____

_____MD Date: _____

_____MD Date: _____

_____MD Date: _____

_____MD Date: _____

_____MD Date: _____