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CONCORD ORTHOPAEDICS
PROFESSIONAL ASSOCIATION

NEW PATIENT HISTORY FORM

Date of First Appointment: ____/____/____ Birthplace: _____

Name: _____ Birthdate: ____/____/____

Address: _____ Age: _____ Sex: F____M____

Telephone: Home (_____) _____ Work (_____) _____

Referred here by: (✓ check one)

_____Self _____Family _____Friend _____Doctor _____Other Health Professional

Name of Person making referral _____

The name of the physician providing your general medical care _____

Do you have an orthopaedic surgeon? _____Yes _____No. If yes, Name _____

Describe briefly your present symptoms:

_____

_____

_____

_____

Date symptoms began (approximate) _____ Diagnosis given (Please list) _____

Previous treatment for this problem (include physical therapy, surgery and injection; medication to be listed later) _____

_____

_____

Please list the names of other practitioners you have seen for this problem: _____

_____

PAST PERSONAL HISTORY:

Do you or have you ever had: (✓ check if "yes")

Cancer _____	Heart Problems _____	Asthma _____	Thyroid Problems _____
Leukemia _____	Stroke _____	Cataracts _____	Diabetes _____
Epilepsy _____	Depression/Anxiety _____	Somach Ulcers _____	Rheumatic Fever _____
Bad Headaches _____	Jaundice _____	Colitis _____	Kidney Disease _____
Pneumonia _____	Psoriasis _____	Anemia _____	High Blood Pressure _____

Other Significant Illnesses (Please list) _____

Previous Operations

Type	*Year*	*Surgeon*	*City*
1)			
2)			
3)			
4)			
5)			
6)			

Any previous fractures? ☐ No ☐ Yes Describe _____

Any other serious injuries? ☐ No ☐ Yes Describe _____

Have you had any Blood transfusions? ☐ No ☐ Yes What year? _____

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of Brothers _____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of Children _____ Number Living _____ Number Deceased _____ List age of each _____

Serious illnesses of children _____

Do you know of any blood relative who has or had: (✓ check and give relation)

Cancer _____ Heart Disease _____ Rheumatic Fever _____ Thyroid Problems _____

Leukemia _____ High Blood Pressure _____ Epilepsy _____ Diabetes _____

Stroke _____ Bleeding Tendency _____ Asthma _____ Tuberculosis _____

Colitis _____ Alcoholism _____ Psoriasis _____ Osteoporosis _____

Arthritis (type unknown) _____ Rheumatoid Arthritis _____ Lupus or "SLE" _____ Childhood Arthritis _____

Osteoarthritis _____ Gout _____ Ankylosing spondylitis _____

Other arthritis conditions: _____

SOCIAL HISTORY:

Never Married _____ Married _____ Divorced _____ Separated _____

Spouse _____ Alive/Age _____ Deceased/Age _____ Major Illnesses: _____

EDUCATION: (circle highest level attended)

Grade School Junior High School 7 8 College 1 2 3 4

High School 9 10 11 12 Graduate School

Occupation: _____ Number of hours worked / average per week _____

HABITS:

Do you drink coffee? _____ Cups per day? _____ Do you smoke? ___Yes ___No ___Past / Cigarettes per day? _____

How much alcohol do you drink/week? _____

Do you use drugs for reasons that are not medical? If so, please list: _____

MEDICATIONS:

DRUG ALLERGIES: _____No _____ Yes To what? _____

_____

Type of reaction? _____

Present: (list any medication you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of Drug	Dose (Include strength and number of pills per day)	How Long Have You Taken This Medication?	Please Check: Helped? A Lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

HOME CONDITIONS:

Check one: ❑ House ❑ Apartment Do you have stairs to climb? ❑ No ❑ Yes If yes, how many? _____

Number of people in household _____ Relationship, and age of each? _____

Who does the housework? _____ Who does most of the shopping? _____

GENERAL FUNCTION: Most of the time, I function (please circle one)...

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty: (✓ check the appropriate response)

	Usually ✓	Sometimes ✓	No ✓
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)			
Walking?			
Climbing stairs?			
Descending stairs?			
Sitting down?			
Getting up from a chair?			
Touching your feet while seated?			
Reaching behind your back?			
Reaching behind your head?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with other family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a cane, crutches, a walker, or a wheelchair? (circle item)			

What is the hardest thing for you to do? _____

Are you receiving disability? ..... Yes _____ No _____

Are you applying for disability? ..... Yes _____ No _____

SYSTEM REVIEW: (✓ check any of those problems which apply to you)

GENERAL:
____ Recent weight gain/amount
____ Recent loss of weight/amount
____ Fatigue
____ Weakness
____ Fever

NERVOUS SYSTEM:
____ Headaches
____ Dizziness
____ Fainting
____ Muscle spasm
____ Loss of consciousness
____ Sensitivity or pain of hands
____ and/or feet
____ Memory loss

EARS:
____ Ringing in ears
____ Loss of hearing

EYES:
____ Pain
____ Redness
____ Loss of vision
____ Double or blurred vision
____ Dryness
____ Feels like something in eye

NOSE:
____ Nosebleeds
____ Loss of smell
____ Dryness

MOUTH:
____ Sore tongue
____ Bleeding gums
____ Sores in mouth
____ Loss of taste
____ Dryness

NECK:
____ Swollen glands
____ Tender glands

THROAT:
____ Frequent sore throats
____ Hoarseness
____ Difficulty swallowing

HEART & LUNGS:
____ Pain in chest
____ Irregular heartbeat
____ Sudden changes in heartbeat
____ Shortness of breath
____ Difficulty breathing at night
____ Swollen legs or feet
____ High blood pressure
____ Heart murmurs
____ Cough
____ Coughing of blood
____ Wheezing
____ Night sweats

STOMACH & INTESTINES:
____ Nausea
____ Vomiting of blood or coffee ground material
____ Stomach pain relieved by food or milk
____ Yellow jaundice
____ Increased constipation
____ Persistent diarrhea
____ Blood in stools
____ Black stools
____ Heartburn

KIDNEYS / URINE / BLADDER:
____ Difficult urination
____ Pain or burning on urination
____ Blood in urine
____ Cloudy, "smoky" urine
____ Pus in urine
____ Discharge from penis/vagina
____ Frequent urination
____ Getting up at night to pass urine
____ Vaginal dryness
____ Rash / ulcers
____ Sexual difficulties
____ Prostate trouble

SKIN:
____ Easy bruising
____ Redness
____ Rash
____ Hives
____ Sun sensitive (sun allergy)
____ Tightness
____ Nodules / bumps
____ Hair loss
____ Color changes of hands or feet in cold

BLOOD:
____ Anemia
____ Bleeding tendency
____ Blood "clots"
____ Phlebitis

MENSTRUAL:
Age when periods began: _____ Periods regular: ____ Yes ____ No How many days apart: _____ Date of last period: _____
Date of last Pap smear: _____ Bleeding after menopause: ____ .

_____ _____
Patient/Guardian Signature **Date**

_____ _____
Provider Signature **Date**