Georgetown University Hospital
MedStar Health

Department of Orthopaedics
Patient History Form
Please Complete Pages 1 and 2

Patient Name_____ Age_____ Today's Date_____

Orthopaedic Problem_____ Date of Onset/Injury_____ Height _____ Weight_____

1. Do you have any food allergies? ☐ Yes ☐ No If yes, please list _____

2. Do you have a known latex allergy? ☐ Yes ☐ No

3. Do you have any medication allergies? ☐ Yes ☐ No If yes, please list _____

_____

4. Please list any significant medical history with dates _____

_____

5. Please list all medications you are currently taking with dosage (including over the counter medications, vitamins & herbals):
ON SECTION 'D' OF THE OUTPATIENT SUMMARY LIST. (See attached form)

6. Please list all surgeries/hospitalizations/fractures and dates _____

_____

7. Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____
Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____

8. Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____

9. Significant family medical history _____

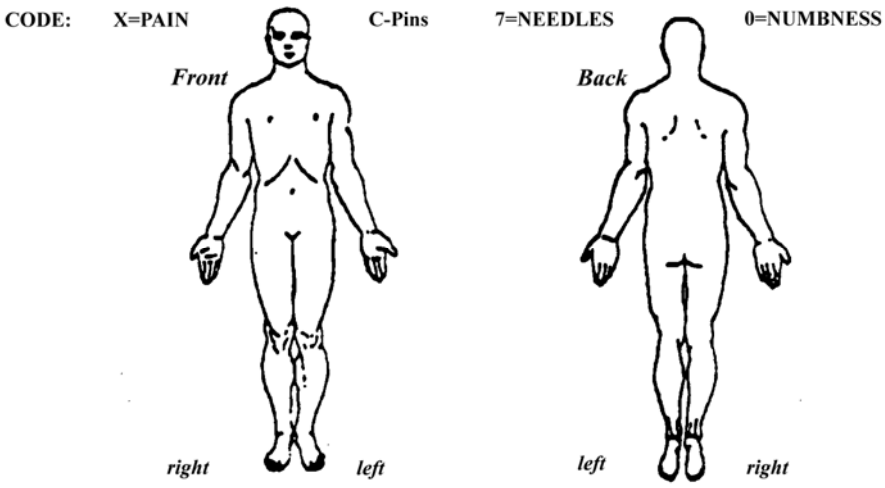
_____

10. Who is available to help at home? _____

11. Please rate the intensity of your pain (please circle):

No pain 1 2 3 4 5 6 7 8 9 10 Worse pain ever

12. Please describe your pain on the drawing below:



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13. Do you currently have or do you have a history of any of the following conditions? If yes, Please list dates.

Allergic Reaction	☐ Yes	☐ No	_____
Anemia	☐ Yes	☐ No	_____
Anorexia/Bulemia	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Asthma/Breathing Difficulties	☐ Yes	☐ No	_____
Bowel/Bladder Difficulties	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____
Chest Pain/Angina	☐ Yes	☐ No	_____
Circulation Disorders	☐ Yes	☐ No	_____
Depression/Psychiatric Disorder	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Dizziness/Fainting	☐ Yes	☐ No	_____
Foot Ulcers	☐ Yes	☐ No	_____
Fractures	☐ Yes	☐ No	_____
HIV	☐ Yes	☐ No	_____
Headaches	☐ Yes	☐ No	_____
Heart Disease of Heart Attack	☐ Yes	☐ No	_____
Heart Palpitations/Arrhythmias	☐ Yes	☐ No	_____
Hepatitis	☐ Yes	☐ No	_____
Hernia	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Kidney Problems	☐ Yes	☐ No	_____
Liver/Gall Bladder Problems	☐ Yes	☐ No	_____
Lung Disease	☐ Yes	☐ No	_____
Malnutrition	☐ Yes	☐ No	_____
Metal Implants	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Pacemaker	☐ Yes	☐ No	_____
Pregnancy (currently)	☐ Yes	☐ No	_____
Problems with Eyesight/Hearing	☐ Yes	☐ No	_____
Pulmonary Embolism	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Skin Abnormalities	☐ Yes	☐ No	_____
Stomach Ulcers	☐ Yes	☐ No	_____
Stroke/Transient Ischemic Attack	☐ Yes	☐ No	_____
Substance Abuse	☐ Yes	☐ No	_____
Thyroid Problems	☐ Yes	☐ No	_____

If yes to any of the above, please explain briefly:

_____
_____
_____

_____ _____

Patient/Responsible Party Signature/ Date Physician Signature/ Date