ORTHOPAEDIC HISTORY FORM

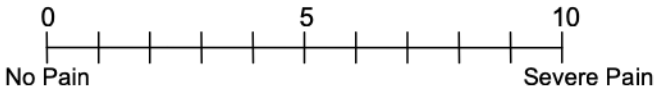
Grigor Grigoryan, M.D.

Date _____ **Referred by** _____

Name (Print) _____ **Age** _____ **Birthdate** _____
Address (Home) _____ **City** _____ **Zip** _____ **Home Phone:** _____
Emergency Contact _____ **Relationship** _____ **Phone:** _____
Height: _____ **Weight:** _____ **Right/Left Handed (circle)** **Occupation:** _____

Primary Care Physician _____

The medical history included here can be of critical importance to you and your physician. Please answer the following items as accurately as possible.

Current Condition	Please Print or Write Answer
For **what** condition or problem are you being seen at this time?	
When did the injury occur or when did the symptoms or condition first begin?	
How did the injury occur or how did the symptoms develop and progress? **Where** did the injury occur?	
How severe is your current pain? **(Please mark on the line)**	
What treatment, if any, have you had? Has this helped?	
Is this **new** or have you had similar symptoms in the past? Please describe.	

Please circle any of the following illnesses you have had or now have and explain below. Also list any not included:

Heart disease	Kidney disease	Neurologic disease	Emotional disorder
Heart attack	Liver disease	Mental illness	Bleeding problems
Irregular heartbeat	Ulcers/gastritis	Chronic infections	Anemia
High blood pressure	Colitis	Cancer	Skin problems
Stroke	Lung disease	Diabetes	Hernia
Blood clots	Asthma	Arthritis	Other _____

Explain:_____

_____

Surgery/Hospitalizations: **When or at what age?**

_____ _____

_____ _____

_____ _____

_____ _____

Allergies/Medication Intolerances:

_____

_____

Medications **Dose/Amount** **Frequency**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History

Marital Status:	Single _____	Married _____	Other _____
Alcohol:	None _____	Occasional _____	Regularly _____
Tobacco	None _____	Yes (packs/day) _____	
Coffee	None _____	Yes (cups/day) _____	

Harmful Substances/Drugs _____

Family History

	Age	Diseases/Conditions or Cause of Death if Deceased
Father	_____	_____
Mother	_____	_____
Brother(s)	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
Sister(s)	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
Other	_____	_____
	_____	_____
	_____	_____

Please circle any of the following symptoms you have and list any not included:

General: Recent weight loss; fever; chills; sleep disorder

Eyes/Vision: Loss or change of vision; double vision; blurred vision; eye diseases; redness; watering

Ears, Nose, Throat: Hearing loss; ringing in the ears; ear infections; nose bleeds; sinus drainage; hay fever; hoarseness; difficulty swallowing; sore throat

Respiratory/Lungs: Wheezing; shortness of breath; frequent or chronic cough; coughing up blood

Cardiovascular: Chest pain; irregular/abnormal heartbeat; palpitations; high blood pressure; varicose veins; cramping in the legs; swelling of the feet/ankles; blood clots

Gatrointestinal: Nausea; vomiting; abdominal pain; indigestion; diarrhea/loose stools; constipation; blood in the stool

Genitourinary: Frequent urination; painful urination; excessive urination; bladder/kidney infections; kidney disease; bloody urine; testicular pain

Neurologic: Headaches; seizures; convulsions; tremors; sciatica; numbness in the arms or legs; loss of consciousness/blacking out; memory loss; dizziness; other

Psychological/Emotional: Nervousness; depression; sleep disorder or insomnia; mental illness

Endocrine: Hormone problems; thyroid disorder; heat or cold intolerance; diabetes; excessive thirst; swollen glands

Hematologic/Lymphatic: Easy bruising or excessive bleeding; anemia; lumps or bumps; lymphedema

Other (not listed above):

_____
_____
_____

Please detail any other health information or conditions:

_____
_____
_____

_____ _____

Signature of patient, parent or guardian **Date**

_____ _____

Signature of physician **Date**