Dhalla Orthopedic Center Inc.
History Form

Name ____Date_____________________

Chief Complaints

1.____for/since_________________________

2.____for/since_________________________

3.____for/since_________________________

History of Present

❑ **Illness**

(a) When did the illness begin? ____

(b) What was the problem at the time? ____

(c) What treatment did you receive? ____

(d) Give details of the treatment, increase/decrease in symptoms and any further injuries, etc.

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❑ **Injury**

(a) Date of injury? ____

(b) How did it happen? ____

(c) Where was the pain? ____

(d) Where were you treated initially? ____

(e) Give all details of the treatment, increase/decrease in symptoms and any further injuries, etc.

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Present Complaints (**Fill one section for each body part**)

1. Pain

(a) Area of pain? ____

(b) Pain constant/ intermittent? ____

(c) Any pain at night? ____

(d) Severity of pain? *On a scale from 1 to 10* (**Slight**) 1 2 3 4 5 6 7 8 9 10 (**Severe**)

(e) What causes or increase pain? ____

(f) What decreases pain? (Position, rest, medicine, etc.?)________________________________

2. Pain

(a) Area of pain? ____

(b) Pain constant/ intermittent? ____

(c) Any pain at night? ____

(d) Severity of pain? *On a scale from 1 to 10* (**Slight**) 1 2 3 4 5 6 7 8 9 10 (**Severe**)

(e) What causes or increase pain? ____

(f) What decreases pain? (Position, rest, medicine, etc.?)________________________________

3. Pain

(a) Area of pain? ____

(b) Pain constant/ intermittent? ____

(c) Any pain at night? ____

(d) Severity of pain? *On a scale from 1 to 10* (**Slight**) 1 2 3 4 5 6 7 8 9 10 (**Severe**)

(e) What causes or increase pain? ____

(f) What decreases pain? (Position, rest, medicine, etc.?)________________________________

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Medications: Name of Medications currently taking

____
____
____
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____
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Past History

1. List all previous injuries:

Type of Injury	Year	Treatment	Residual Disability

2. List all previous surgeries:

Type of Surgery	Year	Surgeon's Name

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3. Any medical illness?

Diabetes	❑ No	❑ Yes
Hypertension	❑ No	❑ Yes
Cardiac illness	❑ No	❑ Yes
Arthritis	❑ No	❑ Yes
Other:	❑ No	❑ Yes

4. Any allergies?

____

____

Family History

Diabetes	❑ No	❑ Yes	Family Member(s) with the illness:
High blood pressure	❑ No	❑ Yes	Family Member(s) with the illness:
Bleeding Problems	❑ No	❑ Yes	Family Member(s) with the illness:
Cancer	❑ No	❑ Yes	Family Member(s) with the illness:
Arthritis	❑ No	❑ Yes	Family Member(s) with the illness:
Osteoporosis	❑ No	❑ Yes	Family Member(s) with the illness:

Social History

❑ Work in the home ❑ Employed (occupation :_____________________) ❑ Student

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Exercise: ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never
What type of exercise?

____

History of substance abuse? ❑ Yes ❑ No What? ____________________________________

____

Smoke currently? ❑ Yes ❑ No __________Packs per day for _________years.

Drink Alcohol? ❑ Daily ❑ 1-2 x/weeks ❑ 1-2 x/weeks ❑ 1-2 x/year

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Systems

Are you currently having or have had problems with:

Explain all YES Responses

Eyes	❑ No	❑ Yes	Explain:
Ears, Nose, Throat	❑ No	❑ Yes	Explain:
Lungs, breathing	❑ No	❑ Yes	Explain:
Digestion	❑ No	❑ Yes	Explain:
Bowel Moment	❑ No	❑ Yes	Explain:
Bladder problem	❑ No	❑ Yes	Explain:
Diabetes	❑ No	❑ Yes	Explain:
High Blood Pressure	❑ No	❑ Yes	Explain:
Bleeding Problems	❑ No	❑ Yes	Explain:
Balance Problems	❑ No	❑ Yes	Explain:
Numbness/Fainting	❑ No	❑ Yes	Explain:
Blackout / Fainting	❑ No	❑ Yes	Explain:
Psychological Problems	❑ No	❑ Yes	Explain:
Cancer	❑ No	❑ yes	Explain:
Arthritis	❑ No	❑ Yes	Explain:
Osteoporosis	❑ No	❑ Yes	Explain:
Polio	❑ No	❑ Yes	Explain:
TB	❑ No	❑ Yes	Explain:
Epilepsy	❑ No	❑ Yes	Explain:

____________________________________ ____________________________________

Patient Signature Interpreter Signature