University of Missouri School of Medicine
Orthopaedic Surgery

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Medical History and Information

Name: ____ Date of Birth: ______________ Date: ___________

Present Complaint

Please check: Left Right Both
Hip Knee

How long has this been a problem and why? ____

Was the problem caused by an accident or injury? Yes No
If yes, what type of incident?
____

Have you ever had surgeries on the above area? Yes No
If yes, please describe the most recent surgery:
Type of surgery:
____
Date of surgery: _____________________ Name of Surgeon: _____________________________________
Please list other surgeries on this area prior to the one above:
____
____

If applicable, please check one in each of the groups to give us more information about your present problem

PAIN
Not controlled with prescription pain medicine
Controlled only with prescription pain medicine
Bearable with non- prescription pain medicine
Relieved by rest
Occasional but not serious
None

STAIRS
Can not climb stairs
1 to 3 steps with great difficulty
One step at a time with support (cane or banister)
One step at a time without support
Step over step with support
Step over step without support

Physician Signature: _________________________ Date: ____________________

Does pain wake you at night? Yes No

Describe the pain (i.e., throbbing, pounding, burning, dull, etc.) ___________________________________

What alleviates or worsens the pain? ____

WALKING	CHAIRS
Bedridden	Can not get in or out of chair by self
Use wheelchair, can transfer by self	Can get in and out of chair with great difficulty and help from another person
Use crutches or walker around the house	Can get in and out of chair by self with chair arm support
1 to 2 blocks, with or without cane or crutch	Can get in and out of chair with minimal arm support
3 to 5 blocks, with or without cane or crutch	Can get in and out of chair with no problem
Unlimited activity	
Length of time walking with aid ___________	

Can you cut your toenails? (check one) Yes No With great difficulty

Medical History

Have you been treated for any of the following illnesses? (please check)

High blood pressure	Depression	Cancer	Diabetes
Immunodeficiency	Stroke	Emphysema/Bronchitis	Epilepsy
Hepatitis	Ulcers	Bleeding Disorder	Heart disease/heart

Please comment on any illness checked: ____

____

Please list all your past surgeries, complications with dates (month/year):

____

____

____

Please list all medications you presently take (include name and dose):

____

____

____

Do you have allergies to any medications or food? Yes No

If yes, please list:____

Do you have any allergies or sensitivity to metals? ____

Physician Signature: __________________________ Date: ____________________

Family History

Please list all diseases/conditions that run in your family (i.e, diabetes, arthritis, bleeding disorders, anesthetic problems, etc.)

____

Mother is alive deceased If deceased, died of ______________________________ Age ________

Father is alive deceased If deceased, died of ______________________________ Age _________

SOCIAL HISTORY

Marital status:	Married	Divorced	Widowed	Single
Do you drink alcohol?	Yes	No	If yes, how much per week: ____________________	
Do you smoke?	Yes	No	If yes, how many packs per day:________________	
Currently employed?	Yes	No		
Disabled?	Yes	No		

Review of Systems (Check all that apply and explain below.)

General
fever
weight loss
fatigue
weakness

Eyes
glasses
visual disturbances
dryness

Blood, lymph
easy bruising
blood disorders

Ear, nose, throat
vertigo
sinusitis
hoarseness

Heart
chest pain
palpitations
murmurs

Lungs
short of breath
asthma
cough
wheezing

Digestive Tract
diarrhea
constipation
ulcers
pain

Skin, breast
rashes
lumps
itching
hair/nail changes

Psychiatric
depression
Anxiety
sleep issue

Endocrine
excess thirst
decreased energy

Kidney, Urinary
stones
burning
urgency
bleeding

Musculo-skeletal
fracture
arthritis
cramps
loss of motion

Neurological
stroke
seizures
tremor
weak

Physician Signature: __________________________ Date: ____________________