ORTHOPAEDIC HISTORY FORM

Michael T. Vercillo, M.D.
vercillomd.com

Date ___________________ **Referred by** ____________________

Name (Print) ____ **Age** ________ **Birthdate** ____________

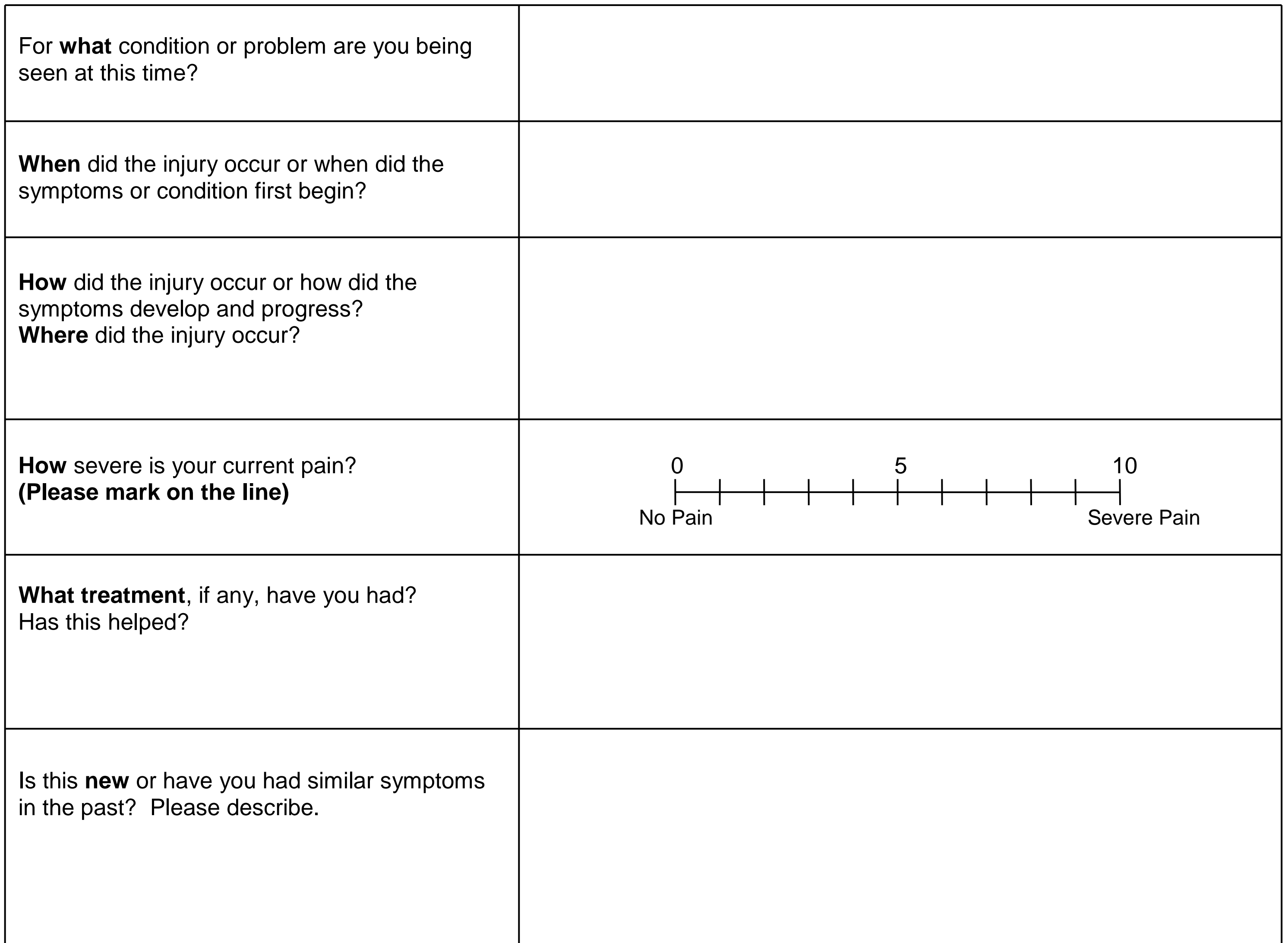
Address (Home) ______________________ **City** __________ **Zip** ________ **Home Phone:** __________________

(Business) ______________________ **City** __________ **Zip** ________ **Bus. 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)**	0 5 10 No Pain Severe Pain
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

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**