Terrence L. Piper, M.D.
Christopher Hemmer, N.P
Theodore Rummel, D.O.

ORTHOPEDIC HISTORY

Name: _____ Height/Weight: _____ Birthdate: _____ Gender: _____

Pharmacy Name/Phone: _____ Referring Physician: _____
_____

History of Current Problem

Describe Problem: _____
When did the problem start? _____ How did the problem start? _____
Current problem is the result of a (check all that apply):
□ Car Accident □ Work Accident □ Sports Injury □ Other: _____
What tests have you had for this problem? □ XRay □ MRI □ Other: _____
What treatments have you had for this problem? _____
What type of work do you do? _____
_____

Pain Rating
Are you experiencing pain? □ YES □ NO Describe the pain: _____

Please circle the number that represents the amount of pain you are having

(No Pain)	0	1	2	3	4	5	6	7	8	9	10	(Worst Pain of Your Life)

Does it disturb your sleep? □ YES □ NO
What makes it feel better? _____ Worse? _____
What are you now unable to do because of this condition? _____

Past Medical History

Condition	Y	N	Condition	Y	N
Sleep Apnea			Diabetes?		
Reflux			Last HbA1c Value? _____		
Taking blood thinner medication?			Anesthetic difficulties?		
High Blood Pressure?			Cancer?		
Coronary artery disease?			Rheumatoid arthritis?		
Congestive Heart Failure?			Blood Clot/ Pulmonary Embolism?		
Asthma?			Osteoporosis?		
COPD?			Gout?		
Hepatitis C?			Kidney disorders?		
HIV?			High Choleserol?		
Other: _____					

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Current Medications (Name and Dose):

_____
_____
_____
_____

Allergies (Name and Type of Reaction):

_____
_____

Past Surgical History:

_____
_____
_____

Family and Social History:

Cancer	□YES	□NO	Alcohol Use	□YES	□NO	drinks/week: _____
Heart Disease	□YES	□NO	Smoking	□YES	□NO	packs/day: _____
Hypertension	□YES	□NO	Drug Use	□YES	□NO	
Osteoarthritis	□YES	□NO				

Other: _____

Review of Systems:

Systemic Symptoms	**Y**	**N**	**Pulmonary Symptoms**	**Y**	**N**
• **Weight Change**			• **Shortness of Breath**		
• **Chills/Fever**			• **Cough**		
• **Night Sweats**			• **Coughing up Blood**		
• **Feeling Tired or poorly**			• **Wheezing**		
HEENT Symptoms			**Cardiovascular Symptoms**		
• **Headache**			• **Chest pain or discomfort**		
• **Eyesight Problems**			• **Fast heart rate**		
• **Nosebleed**			• **Palpitations**		
Genitourinary Symptoms			**Gastrointestinal Symptoms**		
• **Blood in Urine**			• **Difficulty Swallowing**		
• **Painful Urination**			• **Heartburn**		
• **Increased Urinary Frequency**			• **Vomiting**		
Skin Symptoms			• **Abdominal Pain**		
• **Skin infections**			• **Diarrhea**		
• **Skin lesions**			**Hematological Symptoms**		
• **Rashes**			• **Easy bleeding**		
Endocrine Symptoms			• **Easy bruising tendency**		
• **Excessive sweating**			• **Blood clots/Pulmonary Embolism**		
• **Excessive Thirst**			**Neurological Symptoms**		
• **Sleep disturbances**			• **Dizziness**		
Psychological Symptoms			• **Vertigo**		
• **Sleep Disturbances**			• **Loss of strength**		
• **Anxiety**			• **Sensory disturbances**		
• **Depression**			**Other** _____		

Patient Signature: _____ Date: _____

Physician Signature: _____

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