Orthopedics and Sports Medicine
250 Blossom Ste 230 Webster, TX 77598 281-554-4769 281-554-4817 FAX

Conrad A. Fischer, MD
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Orthopedic History

Patient Name (Last, First, MI) :_____Appointment date: _____

Date of Birth:_____ Age: _____ Sex:____Male _____Female

Complaint: (__Right __Left) _____

_____

Duration: _____Days _____ Weeks ___Months ____Years _____No specific event

When does the problem occur (activities, time of day etc):_____

_____

Is this the result of an Injury? **Y / N** Date of injury:_____ Did it occur at work? **Y / N**

Was the injury due to a motor vehicle accident? **Y / N** Were you the? **Driver / Passenger**

Were you wearing a seatbelt? **Y / N** Did the airbag deploy? **Y / N** Do you have an Attorney? **Y / N**

Did you go to the ER? **Y / N** Which Hospital? _____Date: _____

Name of ER Doctor: _____

How was the injury treated: _____

Results of treatment up until now: _____

Things that make symptoms better: _____

Things that make symptoms worse: _____

List any **previous** Orthopedic injuries, conditions, or broken bones related to present condition:

Date	Injury/condition	Treatment (injection, meds, surgeries)	Work Related
_____	_____	_____	**Y / N**
_____	_____	_____	**Y / N**
_____	_____	_____	**Y / N**
_____	_____	_____	Y / N

PAST MEDICAL HISTORY----------

Height: _____Weight:_____ Do you have a personal history of cancer: _____

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Date	Illness/ Diagnosis/Surgery	Date	Illness/ Diagnosis/Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had Anesthesia? **Y / N** Did you have trouble with anesthesia? **Y / N**

If you have complications please describe? _____

MEDICATIONS /ALLERGIES

Please list your **allergies** (medication, iodine, latex, etc): _____

List **blood thinners** (aspirin, plavix, Coumadin) _____

Please list your **MEDICATIONS** and **OVER THE COUNTER** and **SUPPLEMENTS**

Medication (mg)	**WHY (ie HTN, Diabetes)**	**Medication (mg)**	**Diagnosis/ Why?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Education (highest): ___Grade school ___High school ___College ___Graduate Degree_____

Employment: __Student __ Unemployed __ Retired __Work from home ___Employed.. list profession: _____

Marital status: __Single __Married __Divorced __Separated __Widowed

Live alone? **Y / N** Children: **Y / N** Number of Children: _____

Exercise: __ Daily __Weekly __Monthly __Rarely __ Never Type of exercise: _____

Sports Participation: __High School __College __Club __Recreational __Professional

Do you smoke? **Y / N** How many packs per day?_____ For how many Years? _____

Quit smoking? __This year ___>1 yr ago ___>5 yrs Ago ___>10 yrs ago Prior to quitting Packs/day? _____ Years? _____

Do you drink alcohol? **Y / N** How many? ___ daily ___weekly ____monthly ____yearly

Recreational Drug Use? _____

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FAMILY HISTORY----------

	Living?	Age – Medical Problems
Father	**Y / N**	_____
Mother	**Y / N**	_____
Sister / Brother	**Y / N**	_____
Sister / Brother	**Y / N**	_____
Sister / Brother	**Y / N**	_____

REVIEW OF SYSTEMS –CIRCLE all that apply ----------

Constitutional:	N/A	Fever Chills Fatigue Weight Loss Weight Gain Night Sweats
Eyes:	N/A	Blurry vision Double Vision Discharge Dryness
ENT:	N/A	Sore throat Hoarseness Ringing Hearing loss Nose bleeds
Cardio:	N/A	Chest pain Palpitations Swelling in the legs/feet Poor circulation Rapid heartbeat
Respiratory:	N/A	Shortness of Breath Chronic cough Coughing up blood TB
GI:	N/A	Nausea Vomiting Diarrhea Constipation Bloody stool Heart burn
GU:	N/A	Bloody Urine Incontinence Retention Painful urination
SKIN:	N/A	Rash Hives hair loss Sores/ Ulcers Itching
Skeletal:	N/A	Joint pain Muscle aches Weakness Bone pain Joint swelling Back Pain
Psych :	N/A	Anxiety Depression Alcohol/ Drug dependence Panic attacks
Endocrine:	N/A	Heat intolerance Cold Intolerance Thirst Excessive Sweating
Neuro:	N/A	Siezure Tremor Migraines Numbness Stroke Slurred speech Vertigo
Heme:	N/A	Low blood count Easy Bruising Blood Clots
Allergic:	N/A	Frequent infections HIV TB Hepatitis Other_____

Explainations:_____

_____

_____

_____

Patient Signature: _____ Date: _____ Reviewing MD: _____ Date: _____