



OMAHA ORTHOPEDIC CLINIC
 & SPORTS MEDICINE, P.C.
 11704 West Center Road, Suite 200
 Omaha, NE 68144-4327

Physician Use Only
Height _____
Weight _____
Pulse Rate _____

Comprehensive History Questionnaire

Name: _____ Date _____

Occupation: _____

Age _____ Work Related? Yes No If yes, date of injury _____

Who requested that we see you in consultation? _____

Family Physician _____

Chief Complaint: (Brief description of your current orthopedic problem)

Date Problem Originated: _____

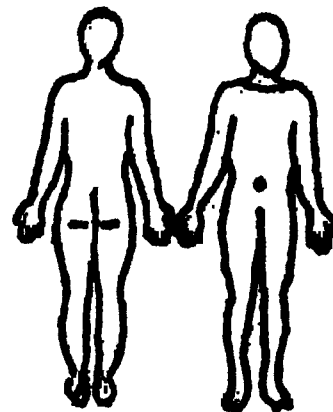
History of Present Illness: (Answer these questions regarding your current orthopedic problem(s) only). You may indicate on the pictogram below.

Where on your body are you having this problem? _____

What symptoms are you having? _____

How long have you had this problem? _____

How did it happen? _____



Name _____ Date _____

Past Medical History:

(Please list medical conditions for which you are followed by a doctor)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Past Surgical History:

(Please list prior surgeries)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies: _____

Medications: (Please list current medications name, dose, and frequency)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Family Medical History: (Please list medical illnesses affecting your immediate family)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Social History: (Please check all that apply)

Single married widowed divorced/separated

Alcohol use (drinks per week): _____ Tobacco use (packs per day): _____

This document was reviewed on the above date by _____.