Today's Date

Last Name		First Name		DOB		AGE
What is the reason for your visit with an orthopaedist today?						
Disabled? (yes/no)		Reason:				
How long have you known about this problem?						
Date of Injury?						
Describe the accident:						

SURGERIES (including Cesarean Births)

Year	Operation	Reason

Other Hospitalizations/ER/URGENT Care Visits/Child Birth

Year	Hospital	Reason

List all Drug Allergies including your reaction to the drug, (Skin, Abdominal, Local, Systemic or Anaphylactic and Mild, Very Mild, Moderate and Severe, Skin, Abdominal, Local, Systemic or Anaphylactic)

Name of Drug	Reaction to Drug

Pharmacy Name Ph# & Fax #	

List your prescribed drugs and over the counter drugs such as Vitamin Supplements, Birth Control and Inhalers

Name the Drug	Strenth	Frequency Taken

Have antibiotics been prescribed within the last 2 weeks? ____Yes/____No

Primary Care Specialist (PCP) & Other Specialists

Name	Ph#	Fax#

Today's Date

Last Name ____________________ First Name ____________________ DOB __________ AGE__________

List all Current and Past Medical Illnesses

		Reason/Circumstance
Blood Transfusions?	_____Yes/_____No	
Bleeding Diathesis? (Bleeding Disorders)	_____Yes/_____No	
Deep Vein Thrombosis? (Blood Clots)	_____Yes/_____No	

Diabetes	_____Yes/_____No	Osteoporosis	_____Yes/_____No	Blood Clots	_____Yes/_____No
Chest Pain/Angina	_____Yes/_____No	Asthma/COPD	_____Yes/_____No	Peripheral Vascular Disease	_____Yes/_____No
High Blood Pressure	_____Yes/_____No	Stroke/CVA/TIA	_____Yes/_____No	Tuberculosis	_____Yes/_____No
Heart Disease	_____Yes/_____No	Seizures	_____Yes/_____No	Depression	_____Yes/_____No
Heart Attack	_____Yes/_____No	HIV/AIDS	_____Yes/_____No	Congestive Heart Failure	_____Yes/_____No
High Cholesterol	_____Yes/_____No	Hepatitis	_____Yes/_____No	Thyroid Disease	_____Yes/_____No
Pacemaker	_____Yes/_____No	Stomach Ulcer	_____Yes/_____No	GERD/REFLUX	_____Yes/_____No
Headaches	_____Yes/_____No	Liver Disease	_____Yes/_____No	Gout	_____Yes/_____No
Kidney Stones	_____Yes/_____No	Heart Palpitations	_____Yes/_____No	Other	_____Yes/_____No
Kidney Disease	_____Yes/_____No	Arthritis	_____Yes/_____No		
Cancer	_____Yes/_____No	Heart Surgery	_____Yes/_____No		

Have any of your BLOOD relatives had any of the following?

	List Relationship
Ulcers	
Stroke	
Gout	
Diabetes	
Bleeding Disorder	
High Blood Pressure	
Heart Attack/Disease	
Cancer	
Other	

Social/HEALTH HABITS AND PERSONAL SAFETY (mark with an X)

Marital Status ☐Single ☐ Partnered ☐Married ☐ Separated ☐ Divorced ☐Widowed

Occupation

Alcohol	Do you drink alcohol?	Yes _____		No _____
	How many drinks per week?			
Tobacco	Do you use tobacco?	Yes _____		No _____
	Cigarettes – pks./day _____ /amt per day_____________	Chewing Tobacco-#/day ______/amt per day_______	Pipe-#/day ______/amt per day_______	Cigars-#/day ______/amt per day
	# of years_______________________	Or year quit_________		

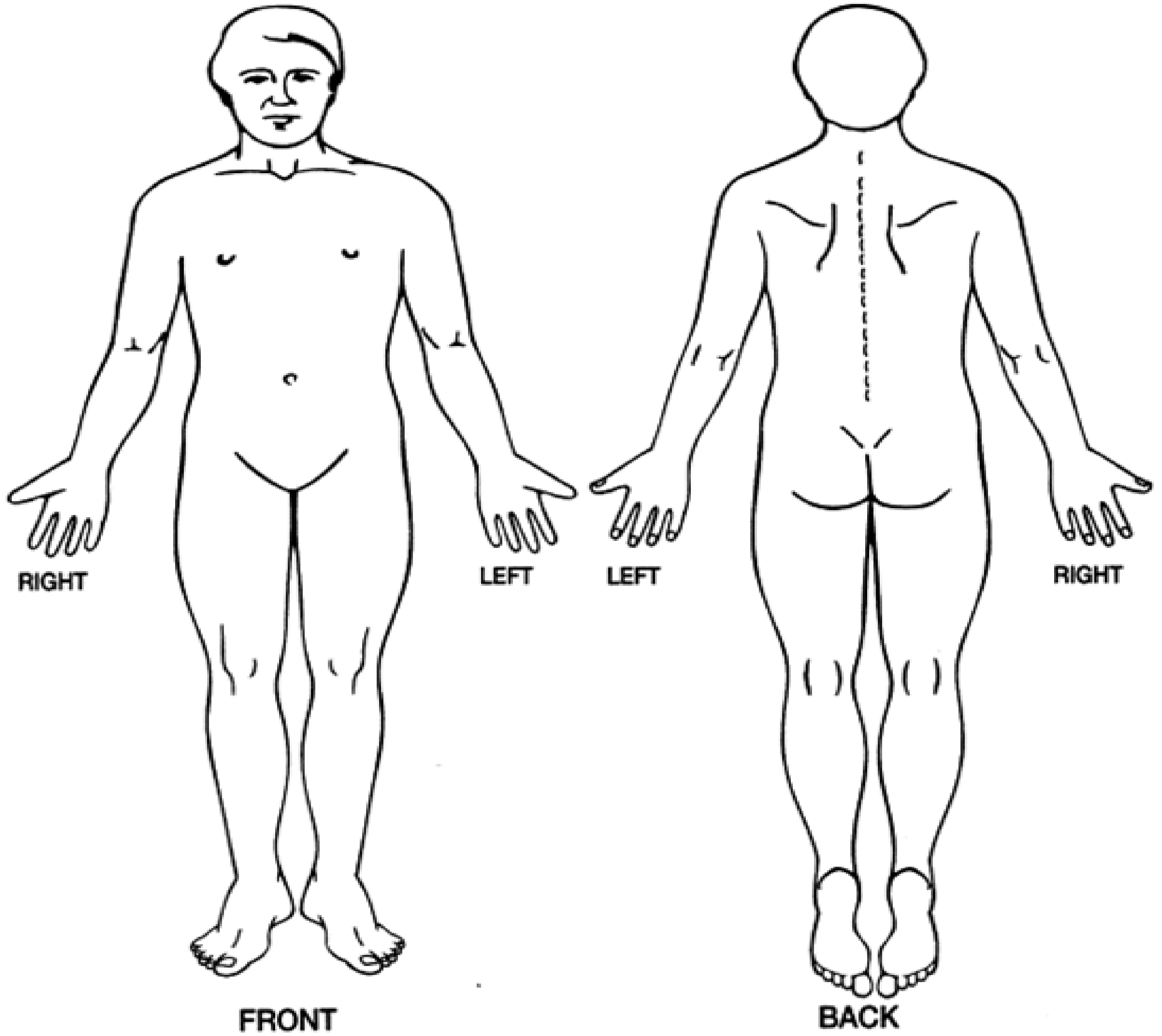
Preventative Care

Exercise	Sedentary (No exercise)		
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Vitamins			
Nutrition History/Special diets etc			

Today's Date

Last Name		First Name		DOB		AGE

Please fill out the pain drawing, mark the area(s) on your body where you feel pain



Patient/Guardian Signature

Date