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ORTHOPEDICS

TODAY'S DATE: ______________________

NAME ____________________________________ DATE OF BIRTH _______________ AGE ___________

ADDRESS ________________________________ REFERRING PHYSICIAN ______________________

CITY ____________________________________ OTHER PHYSICIANS _________________________

STATE _________________ ZIP ___________ SOCIAL SECURITY NO.________________________

HOME PHONE ____________________________ OCCUPATION ________________________________

CELL PHONE ____________________________ EMPLOYER'S NAME ___________________________

EMAIL ADDRESS __________________________ EMPLOYER ADDRESS/PHONE _____________________

PHARMACY _______________________________ ____

____

MARITAL STATUS (Circle One) SINGLE MARRIED DIVORCED SEPARATED WIDOW

SPOUSE'S NAME_____________________ SPOUSE'S OCCUPATION__________________

SPOUSE'S EMPLOYER_________________ NO. OF CHILDREN______________________

ILLNESS ☐ OR ACCIDENT ☐ - DATE OF ACCIDENT _____________________

REASON FOR YOUR VISIT TODAY:

____

____

____

PAST MEDICAL HISTORY

MEDICAL PROBLEMS:	SURGERIES:	DATES	MEDICATIONS:	DOSAGE
			List all Medication you take: (Include Tylenol, AspIrin, Birth Control Pills, vitamins & herbal remedies) (include dosage & frequency):	

ALLERGIES TO MEDICATIONS _______________________ ____________________________

_____________________ _____________________ _____________________

HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION?_______EVER HAD HEPATITIS?____________________

EVER BEEN TESTED FOR AIDS?___________________IF YES, RESULT:__________________________

PHYSICAL CONDITION: Do you exercise regularly?_____________ Doing what?______________________

Height:__________ Current Weight:______________ Weight 2yrs. Ago____________ Are you "In Shape"?__________

SMOKING: Do you Smoke?_____________ How long?_______________ Packs Per Day____________________

(If former smoker), Year you quit smoking ____

ALCOHOL: How often do you drink?________________________ Usual number of drinks______________________________

Ever been treated for alcohol/drug abuse? ____

ORTHOPEDIC HISTORY

Have you ever had any of the following? (If yes, give dates below)

______ major joint injury (ligament injury/dislocation) ____

______ a fracture (broken bone) _________________________

______ arthritis _______________________________________

______ back pain

______ neck pain

______ leg pain ___________________________________

______ nerve/muscle injury _________________________

______ numbness/tingling

REVIEW OF SYSTEMS – DO YOU CURRENTLY HAVE PROBLEMS WITH:

1. Dizziness _________________
2. Fainting spells______________
3. Shortness of Breath__________
4. Chronic Cough _____________
5. Chest Pains ________________
6. Heart Palpitations____________
7. Abdominal Pain _____________
8. Constipation ________________
9. Diarrhea ____________________
10. Frequent Urination____________
11. Phlebitis/blood clots___________

FAMILY HISTORY

MOTHER: Age (or Age at death) _________________________ If Deceased, Cause ______________________________

Health problems During Life ____

FATHER: Age (or Age at death) _________________________ If Deceased, Cause _______________________________

Health problems During Life ____

BROTHERS & SISTERS: NUMBER OF BROTHERS _________________ NUMBER OF SISTERS ________________

IS THERE A HISTORY IN YOUR FAMILY OF:

1. Anesthetic Problems ____________________________
2. Early heart attack (before age 60) _________________
3. Early stroke (before age 60) _______________________
4. Diabetes _______________________________________
5. High blood pressure _____________________________
6. Cancer ______________________________
7. Bleeding Disorders _____________________
8. Sickle Cell Anemia _____________________
9. Arthritis ______________________________

UPDATED BY PARENT/GUARDIAN	DATE:	REVIEWED DATE:
Signature:		
Signature:		
Signature:		
Signature:		
Signature:		
Signature:		