Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: **M F Other** Marital Status\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to release medical information: **Y N**

Insurance Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone for PCP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Today's Visit:** **R**ight / **L**eft / **B**oth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When started\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**

|  |  |
| --- | --- |
| **Medications, foods, environmental** | **Reaction** (Rash, hives, swelling, throat closing…) |
|  |  |
|  |  |
|  |  |

**Medications** (including vitamins/supplements

|  |  |
| --- | --- |
| **Medication name** | **Dose and Frequency** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Please turn page over**

Please list all **past surgeries** and the approximate date.

|  |  |  |
| --- | --- | --- |
| **Procedure** | **Date** | **Complications** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Prior **Orthopedic problems** and the approximate date.

|  |  |
| --- | --- |
| **Orthopedic Condition** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Are you being treated for or have you been diagnosed with any of the following **medical conditions**:

Asthma/Breathing Problems......................... □ Y □ N Heart Disease/Disorder ...........................□ Y □ N Arthritis......................................................... □ Y □ N Lung Disorder...........................................□ Y □ N Bleeding/Clotting Disorder............................ □ Y □ N Liver Disease ............................................□ Y □ N Blood Pressure Disorder................................ □ Y □ N Neurological Disorder/ Headaches ……....□ Y □ N Blood Transfusion ......................................... □ Y □ N Psychiatric Disorder/Illness......................□ Y □ N Bowel/Stomach Problems............................. □ Y □ N Pulmonary Embolism/DVT.......................□ Y □ N Cancer........................................................... □ Y □ N Stroke.......................................................□ Y □ N Cholesterol Disorder ..................................... □ Y □ N Seizure or Epilepsy ..................................□ Y □ N Diabetes........................................................ □ Y □ N Thyroid Disorder .....................................□ Y □ N Eye Disorder (i.e. Glaucoma, cataract).......... □ Y □ N Urinary/Kidney Disorder..........................□ Y □ N If Relevant: Gynecological Issues……………….. □ Y □ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tobacco Smoking History** (circle): Current daily smoker Current occasional smoker

Former smoker Year quit\_\_\_\_\_\_\_\_\_\_\_\_ Never smoked

**Alcohol intake** (circle): Daily # drinks\_\_\_\_\_\_ Socially Rarely Don't drink

**Drug use** (circle): Never Occasional Frequent Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recreational activities** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family** medical history.

|  |  |
| --- | --- |
| **Medical Conditions in the Family** | **Relation** |
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|  |  |
|  |  |

**Review of Systems**.

Please indicate ALL that you have experienced within the past 6 – 12 months (circle).

Y N Fever/Chills Y N Headache Y N Dizziness Y N Weakness

Y N Shortness of Breath Y N Cough Y N Chest pain Y N Palpitations

Y N Nausea Y N Vomiting Y N Diarrhea Y N Constipation

Y N Burning on urination Y N Rashes Y N Itching Y N Bruising

Y N Bloody noses Y N Depression Y N Anxiety Y N Excessive thirst

Y N Joint pains Y N Blurry vision Y N Double vision Y N Hearing problems

By signing below, I acknowledge that I have received and reviewed the "Notice of Privacy Practices".

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Signature** (for minors) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_