

Orthopaedics Date: Age: Date of Birth: Name: Preferred name to be called: Who referred you: Primary Care Physician: Height: ___ Weight: ___ Date of your last flu vaccine: Date of your last pneumonia vaccine: **CURRENT CONDITION:** Current Orthopaedic Complaint: **Elbow** Knee Shoulder Wrist Ankle Hip **Spine** ROLO ROLO ROLO ROLO ROLO NeckO Lower Back O ROLO Are you right or left handed? Date of onset of injury/problem: Is your injury/problem related to: **auto accident** work related accident MEDICAL CONDITIONS Do you currently have or have you ever had any of the following conditions? **Condition** Condition HEART DISEASE/CHEST PAIN Yes □ No □ PNEUMONIA/BRONCHITIS Yes □ No □ HEART VALVE PROBLEMS/MURMUR Yes □ No □ EMPHYSEMA/COPD Yes □ No □ HIGH BLOOD PRESSURE Yes □ No □ SINUS PROBLEMS Yes □ No □ Yes \square No \square HEARTBURN/REFLUX/ULCER DIABETES Yes □ No □ LIVER DISEASE/HEPATITIS Yes □ No □ THYROID DISEASE Yes □ No □ ANEMIA RHEUMATOID ARTHRITIS Yes □ No □ Yes □ No □ Yes □ No □ BLEEDING DISORDER **GOUT** Yes □ No □ BLOOD CLOTS/DVT Yes □ No □ **OSTEOARTHRITIS** Yes □ No □ KIDNEY DISEASE Yes □ No □ SLEEP APNEA Yes □ No □ KIDNEY STONES Yes □ No □ FRACTURE/BROKEN BONE Yes □ No □ ASTHMA Yes □ No □ Yes □ No □ **CANCER** SHORTNESS OF BREATH Yes □ No □ NEUROLOGICAL DISORDER Yes □ No □ Psychiatric/Emotional Disorders:

If not listed above, please list any other **MEDICAL CONDITIONS**:

FAMILY HISTORY: Mother: Living or Deceased Father: Living or Deceased Family Member Family Algers Family Algers Family Member Family Algers Family Algers Family Algers Family No Decease Family Algers Family Algers Family Algers Family No Decease Family Algers Family Algers Family Algers Family No Decease Family Algers Family Algers Family Algers Family No Decease Family Algers Famile Algers Famile Algers Famile	YOUR SURGICAL HISTORY: Procedure:	Date:
FAMILY HISTORY: Mother: Living or Deceased Father: Living or Deceased I am adop Family Member Father: Living or Deceased I am adop Family Member Family Member Family Member Father: Living or Deceased I am adop High Cholesterol: Yes No Hypertension: Yes No Mother: How many in the properties of		
Mother: Living or Deceased Father: Living or Deceased I am adoj Family Member		
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Cancer: Yes No High Cholesterol: Yes No Hypertension: Yes No Diabetes I or II: Yes No Thyroid Disease: Yes No Other: Widowed Heart Disease: Yes No Thyroid Disease: Yes No Widowed Do you have any children: How many: Are you working now? What type of exercise/sports do you participate in: Current Smoker: How many packs/day Number of years: Do you drink alcohol? Yes No How much and how often? History of substance abuse? Yes No If yes, please describe: Is there any possibility that you are pregnant? Yes No (If yes, please inform staff pri Please list all CURRENT MEDICATIONS/DOSES: You may provide our staff with a seminate process of the provided in the provi	· ·	
Cancer Type: Hypertension: Yes No Diabetes I or II: Yes No Thyroid Disease: Yes No Heart Disease: Yes No Other: Provided Disease: Yes No Heart Disease: Yes No Other: Partnered Separated Divorced Widowed Do you have any children: How many: Are you working now? What type of exercise/sports do you participate in: Current Smoker: How many packs/day Number of years: Promer Smoker: Never a Smoker: Do you drink alcohol? Yes No How much and how often? History of substance abuse? Yes No If yes, please describe: Is there any possibility that you are pregnant? Yes No (If yes, please inform staff pri Please list all CURRENT MEDICATIONS/DOSES: You may provide our staff with a seminant provide our staff with a seminant provided Dosage Times provided Dosage		
Diabetes I or II: Yes No Thyroid Disease: Yes No Heart Disease: Yes No Other: YOUR SOCIAL HISTORY: Single Married Partnered Separated Divorced Widowed Widowed Do you have any children: How many: Are you working now? What type of exercise/sports do you participate in: Current Smoker: How many packs/day Number of years: Former Smoker: Never a Smoker: Do you drink alcohol? Yes No How much and how often? History of substance abuse? Yes No If yes, please describe: Is there any possibility that you are pregnant? Yes No (If yes, please inform staff pri) Please list all CURRENT MEDICATIONS/DOSES: You may provide our staff with a seminated from the provided of the pri		Hypertension: Yes No
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Please list all CURRENT MEDICATIONS/DOSES: You may provide our staff with a s Medications Dosage Times p ALLERGIES TO MEDICATIONS:	History of substance abuse? Yes □ □	No □ If yes, please describe:
Medications Dosage Times p ALLERGIES TO MEDICATIONS:	Is there any possibility that you are pregn	nant? Yes \square No \square (If yes, please inform staff prior to x-rays.)
ALLERGIES TO MEDICATIONS:	Please list all CURRENT MEDICATIO	ONS/DOSES: You may provide our staff with a separate written li
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