Carroll Health Group

Orthopaedics Date:_____

Name: _____ Age: _____ Date of Birth: _____
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**
R O L O	R O L O	R O L O	R O L O	R O L O	R O L O	Neck O Lower Back O

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 ☐
HEARTBURN/REFLUX/ULCER	Yes ☐ No ☐	DIABETES	Yes ☐ No ☐
LIVER DISEASE/HEPATITIS	Yes ☐ No ☐	THYROID DISEASE	Yes ☐ No ☐
ANEMIA	Yes ☐ No ☐	RHEUMATOID ARTHRITIS	Yes ☐ No ☐
BLEEDING DISORDER	Yes ☐ No ☐	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 ☐	CANCER	Yes ☐ No ☐
SHORTNESS OF BREATH	Yes ☐ No ☐	NEUROLOGICAL DISORDER	Yes ☐ No ☐
Psychiatric/Emotional Disorders:_____			

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

_____

YOUR SURGICAL HISTORY:

Procedure:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY:

Mother: Living or Deceased **Father**: Living or Deceased **I am adopted:** yes or no

	Family Member		Family Member
Cancer: Yes No	_____	High Cholesterol: Yes No	_____
Cancer Type: _____		Hypertension: Yes No	_____
Diabetes I or II: Yes No	_____	Thyroid Disease: Yes No	_____
Heart Disease: Yes No	_____	Other:_____	_____

YOUR SOCIAL HISTORY:

Single_____ Married _____ Partnered _____ Separated _____ Divorced _____ Widowed _____

Do you have any children:_____ How many:_____

Occupation: _____ Are you working now? Yes ☐ No ☐

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 prior to x-rays.)**

Please list all **CURRENT MEDICATIONS/DOSES**: You may provide our staff with a separate written list

Medications	Dosage	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDICATIONS:_____

Patient Signature: _____ Date: _____