

Orthopedics Specialists, LLC

NAME: _____ **AGE:** _____ **HEIGHT:** _____ **WEIGHT** _____

SSN: _____ **DOB:** _____ **DOMINANT HAND:** R or L

BEST PHONE NUMBER TO CONTACT YOU: _____ (home / work / mobile)

PREFERRED E-MAIL ADDRESS (PRINT LEGIBLY): _____

What physician referred you to our office?

Who is your regular physician?

What are you seeing the doctor for?

When and how did your condition start?

Is this problem work-related?

What have you tried for this problem?

What are your main concerns and what questions would you like the doctor to answer today?

Medical Problems: *Circle any of the problems below you have now or have had in the past*

Anemia	Arthritis	Asthma	Birth Defect	Bladder Problems
Bleeding Disorders	Blood Clots	Bowel Problems	Cancer	Currently Pregnant
Diabetes	Epilepsy	Heart Disease	Hepatitis	High Blood Pressure
Kidney Disease	Lung Problems	Phlebitis	Polio	Psychological
Recurrent Infections	Stroke	TB	Ulcers	

Other problems not listed:

Past Surgeries:

Allergies to medications:

Are you currently taking any **medications** (prescription or over-the-counter)?
(List the medication, dosage, and how often you take them)

PLEASE FILL OUT BOTH SIDES

Social History:

What is your occupation?

Who resides with you?

How many alcoholic drinks per week do you consume?

How much tobacco do you use per day?

Do you or have you ever used illicit drugs?

Family History: Do any medical problems such as arthritis, cancer, diabetes, heart disease or other run in your family? *Please list:*

Review of Systems: *(circle those that apply to you)*

GENERAL: fever / chills / night sweats / weight gain / weight loss

SKIN: rashes / easy bruising / redness

HEAD: headache / fainting / blackouts/ trauma

CARDIOVASCULAR: chest pain / rapid heartbeat / faintness / swelling around ankles

GASTROINTESTINAL: nausea / vomiting / constipation / diarrhea / bloody stools / abdominal pain

MUSCULOSKELETAL: numbness / weakness / joint pain / tingling / deformities / heat

RESPIRATORY: chest pain / shortness of breath / difficulty breathing / cough

OTHER COMPLAINTS:

Is there anything else you want us to know about your medical history?

SIGNATURE

DATE