

Welcome to ORTHOPAEDIC ASSOCIATES, INC.

Name: _____ Today's date: _____
Address: _____ Date of Birth: _____
_____ Soc. Security #: _____
Phone: (home) _____ (work) _____ (wireless) _____
In case of emergency, please notify: _____ Phone: _____
Primary Care Doctor: _____ City/State _____ Phone: _____
Referring Doctor: _____ City/State _____ Phone: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____
Address: _____ Supervisor: _____
_____ Phone: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____
Cardholder name: _____ Date of Birth: _____ Copay: _____
Soc. Security #: _____ Employer: _____

Secondary Insurance: _____ Policy #: _____
Cardholder name: _____ Date of Birth: _____ Copay: _____
Soc. Security #: _____ Employer: _____

If insurance is in someone else's name, please complete the following:

Address: _____ Relationship to you: _____
_____ Phone: _____

MEDICAL INFORMATION

Why are you seeing the doctor today? (right knee pain, left hand numb, etc.) _____

Did you injure yourself? ___ If so, what was the date? _____ Place first treated _____
List any tests that have already been done _____

Your height: _____ Your weight: _____ (office use only: HR _____)

Continued

PAST MEDICAL HISTORY

Have you ever had?
(please check all that apply):

- ◇ Stroke
- ◇ Seizures/epilepsy
- ◇ Migraines
- ◇ Mental illness (depression, etc.)
- ◇ Thyroid disease
- ◇ Heart disease/failure/attack
- ◇ Heart rhythm problem
- ◇ High blood pressure
- ◇ High cholesterol
- ◇ Diabetes
- ◇ Pneumonia
- ◇ COPD/asthma/TB
- ◇ Hepatitis
- ◇ Cirrhosis of the liver
- ◇ Anemia
- ◇ AIDS
- ◇ Stomach ulcers
- ◇ GERD/ stomach reflux
- ◇ Gallstones
- ◇ Kidney stones
- ◇ Kidney failure
- ◇ Cancer (type) _____
- ◇ Arthritis
- ◇ Gout
- ◇ Phlebitis/varicose veins/ blood clots
- ◇ Substance abuse (alcohol, drugs)
- ◇ Anesthesia problems
- ◇ Other: _____

Previous Surgeries

1. _____
2. _____
3. _____
4. _____

Continued

Current **MEDICATIONS** and dosages

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ALLERGIES to medications

1. _____
2. _____
3. _____

SOCIAL HISTORY

Do you smoke? _____ amount per day: _____
Alcohol use? _____ amount per day: _____
Marital Status: _____ # of children: _____
Who lives with you at home? _____

FAMILY HISTORY

Mother's age _____ (living or deceased)
Father's age _____ (living or deceased)
Brothers/sisters and ages: _____

Has anyone in your family *ever* had?
(please check all that apply):

- ◇ Stroke
- ◇ Heart disease
- ◇ Lung disease
- ◇ Diabetes
- ◇ High blood pressure
- ◇ Cancer (type): _____
- ◇ Arthritis at a young age
- ◇ Lupus, gout, rheumatoid arthritis
- ◇ Ulcerative colitis or Crohn's disease

Continued

REVIEW OF SYSTEMS

Are you currently having or have you *ever* had recurrent problems with (*check all that apply*):

- ◇ Loss of or double vision
- ◇ Loss of hearing
- ◇ Ear pain
- ◇ Frequent nosebleeds
- ◇ Difficulty swallowing
- ◇ Shortness of breath
- ◇ Wheezing
- ◇ Chest pain/angina
- ◇ Irregular heartbeat
- ◇ Swollen ankles (both)
- ◇ Calf cramps with walking
- ◇ Nausea and vomiting
- ◇ Stomach pain or ulcers
- ◇ Bladder problems
- ◇ Burning or frequent voiding
- ◇ Jaundice or liver problems
- ◇ Seizures
- ◇ Fainting/blackouts
- ◇ Dizziness or balance problems
- ◇ Insomnia
- ◇ Depression or anxiety
- ◇ Severe headaches
- ◇ Fever/chills
- ◇ Nightsweats
- ◇ Unexplained weight loss/gain
- ◇ Rashes
- ◇ Lyme disease
- ◇ Bleeding problems

Continued

IF YOUR CURRENT PROBLEM IS THE RESULT OF A WORK INJURY OR LIABILITY, PLEASE COMPLETE THE FOLLOWING:

Circle all that apply: Car accident Work accident Slip/fall
Other: _____

Cause of injury: _____

Did you report this? _____

Date you last worked: _____

Date you returned to work: _____

If applicable, your Attorney's name/address: _____

Phone: _____

I understand that the answers and explanations that I have provided on these 5 pages are important for my safety during and after treatment and/or surgery, and I therefore certify that this information is true and accurate to the best of my knowledge.

Signed: _____

Printed name: _____

Date: _____

(for office use only)

Reviewed: _____

Date: _____