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 INFORMATON

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 INFORMATON

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 <u>all</u> 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 **<u>MEDICATIONS</u>** 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 <u>all</u> 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: _____