ORTHOPEDIC SURGERY, P.C.

HISTORY OF PRESENT ILLNESS

Name: ________________________ Date of Birth: ____________ SS #____________

Reason for visit: ______________________________Date injury/symptoms began: __________

If an injury, how did it occur? ____

Where did it occur? ____________________ Have you been treated before for this problem? Yes/No

When? ____________________ By whom? ______________________________

Referral Source:______________________ Ht: __________Wt: __________ Pulse: _________

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS

List complete names of other doctors you have seen in the last five years: ____________________

____

Do you or have you had problems with any of the following (Circle "Y" for "yes" and "N" for "no"):

Eyes	Y	N	Dizziness	Y	N	Ears	Y	N	Joint Problems	Y	N
Headache	Y	N	Convulsions	Y	N	Nose	Y	N	Tumor	Y	N
Paralysis	Y	N	Nervous Disorders	Y	N	Throat	Y	N	Cancer	Y	N
Lung Disease	Y	N	High Blood Pressure	Y	N	Stroke	Y	N	Fainting	Y	N
Chest Discomfort	Y	N	Jaundice	Y	N	Asthma	Y	N	Liver Disease	Y	N
Heart Murmur	Y	N	Hernia	Y	N	Tuberculosis	Y	N	Hemorrhoids	Y	N
Intestinal Bleeding	Y	N	Gall Bladder Dis.	Y	N	Heart Attack	Y	N	Sciatica	Y	N
Diabetes	Y	N	Neuritis	Y	N	Ulcers	Y	N	Breasts/Genitals	Y	N
Arthritis	Y	N	Skin Disorders	Y	N	Thyroid Disease	Y	N	Alcohol	Y	N
Cysts	Y	N	Drugs	Y	N	Gout	Y	N	Weight	Y	N

Provide details for any problems you have listed above: ______________________________

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Do you have any problems not stated above? N / Y If "Yes," describe:____________________

List any orthopedic surgeries you have had in the past: ______________________________

List any other surgeries you have had in the past: __________________________________

Are you taking any medications? No / Yes If "Yes," list:______________________________

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Are you allergic to any medications? No / Yes If "Yes," list: __________________________

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FAMILY/SOCIAL HISTORY

Marital Status: _______ Occupation: ________________ Circle all of the following that apply to family members and indicate which family member: Cancer ______________ Diabetes ________________

Stroke______________ Kidney Disease ______________ Heart Disease ______________

Other____

Do you smoke? Y/ N # of packs per day? _____ Do you drink alcohol? Y / N How much? ____________

MD REVIEWED ________________ DATE __________

Revised 3/03