

PHYSICIAN TO BE SEEN: \_\_\_\_\_

What problem are we seeing you for today? \_\_\_\_\_ Date of Onset \_\_\_\_\_

**PATIENT'S INFORMATION**

NAME: Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referred to us by: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**SEX:**  Male  Female    **Marital Status:**  Single  Married  Divorced  Legally Separated  Widowed

**What is your current occupation?** \_\_\_\_\_

**Are You:**  Right-handed  Left-handed    **Do you smoke?**  Yes  No    Packs Per Day \_\_\_\_\_ How many years? \_\_\_\_\_

**Do you drink alcohol?**  No  Rarely  Weekly  Daily

**DO YOU HAVE ANY DRUG ALLERGIES?**  No  Yes

Anti-inflammatory Drugs     Penicillin     Iodine     Sulfa Drugs  
 Codeine     Aspirin     Latex     Other: \_\_\_\_\_

**DO YOU TAKE ANY MEDICATIONS (include over-the-counter medicines and eye drops)?**  No  Yes

Name.....Dosage/Frequency	Name.....Dosage/Frequency
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**Any recreational drug use?**  No  Yes

**DO YOU TAKE ANY HERBAL OR NUTRITIONAL SUPPLEMENTS?**  No  Yes

Name.....Dosage/Frequency	Name.....Dosage/Frequency
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**HAVE YOU EVER HAD SURGERY?**  No  Yes **(LIST ORTHOPAEDIC SURGERIES FIRST)**

Type _____	Right _____	Left _____	Date _____
Type _____	Right _____	Left _____	Date _____
Type _____	Right _____	Left _____	Date _____
Type _____	Right _____	Left _____	Date _____
Type _____	Right _____	Left _____	Date _____
Type _____	Right _____	Left _____	Date _____
Type _____	Right _____	Left _____	Date _____

**HAVE YOU EVER HAD A DEXA (Bone Density for Osteoporosis)?**  No  Yes **If so, when & where** \_\_\_\_\_

**YOUR ACTIVE/CURRENT MEDICAL HISTORY: (current or major past medical problem)**

**EYES:**

- Glaucoma       Vision Loss/Blindness
- Other: \_\_\_\_\_

**STOMACH/INTESTINAL:**

- GERD (gastro-esophageal reflux disease)
- Ulcers       Other: \_\_\_\_\_

**HEART:**

- Hypertension (high blood pressure)
- Congestive heart failure
- Coronary heart disease
- Heart valve problem
- Heart murmur       Angina (chest pain)
- Myocardial infarction (heart attack) If so, when: \_\_\_\_\_
- Implanted pacemaker or defibrillator
- Other: \_\_\_\_\_

**LUNG/RESPIRATORY:**

- Asthma
- Obstructive sleep apnea
- COPD/emphysema/chronic bronchitis
- Pneumonia, if so were you hospitalized       Yes       No
- Other: \_\_\_\_\_

**PSYCHOLOGICAL DISORDERS:**

- Depression       Other: \_\_\_\_\_

**BLOOD DISORDERS**

- Coumadin therapy       Aspirin       Plavix
- Other: \_\_\_\_\_

**OTHER DIAGNOSIS NOT LISTED:** \_\_\_\_\_

**NEUROLOGICAL:**

- TIA (Transient ischemic attacks)
- Seizures/epilepsy       Stroke \_\_\_\_\_
- Nerve injury, of where and circumstances \_\_\_\_\_
- Other \_\_\_\_\_

**MUSCLE/JOINT:**

- Osteoarthritis       Rheumatoid arthritis
- Fractures       Other \_\_\_\_\_
- History of fractures, if so where \_\_\_\_\_

**URINARY/BLADDER PROBLEMS:**

- Stress/urge incontinence       Gynecological problems
- Frequent urinary tract infections       Other \_\_\_\_\_

**ENDOCRINE (GLAND) DISORDERS:**

- Thyroid (hyper/hypo)       Osteoporosis
- Diabetes Mellitus (Type 1 or 2)       Other \_\_\_\_\_
- Chronic steroid use (Prednisone)

**SKIN DISORDERS:**

- Eczema       Chronic use of topical steroids
- Other \_\_\_\_\_

**IMMUNE SYSTEMS/INFECTIONS:**

- Lupus (SLE)       Hepatitis (A/B/C)
- HIV/ARC/AIDS       Other \_\_\_\_\_
- TB

**CANCER:**

- Breast       Lung       Thyroid       Prostate       Kidney
- Brain       Skin       Other \_\_\_\_\_

**NONE OF THE ABOVE**

**FAMILY MEDICAL HISTORY: Any family history of:**

- Heart Disease       Anyone with history of heart attack age 50 or younger       Stroke       Diabetes
- Osteoarthritis       Rheumatoid Arthritis       Other: \_\_\_\_\_

**Any personal or family history of reaction to anesthesia?**       Yes       No

Explain: \_\_\_\_\_

**Continued on Next Page**

## REVIEW OF SYSTEMS

Have you had any of these *symptoms* or *changes* in your medical history in the past few months

### HEARING, EYES, EARS, NOSE & THROAT:

- Hearing Problems
- Chronic sinus infections
- Visual disturbances/blurred vision
- Sudden loss of vision

### HEART:

- Chest pain/discomfort
- Short of breath (SOB)
- SOB with exertion
- Awakening at night SOB
- Chronic swelling of legs/edema

### LUNG/RESPIRATORY:

- Difficulty breathing
- Use over-the-counter breathing aids
- Chronic cough
- Coughing up blood

### STOMACH/INTESTINAL:

- Chronic upset stomach
- Frequent nausea/vomiting
- Vomiting up blood
- Blood in stool
- Chronic constipation/diarrhea

### PSYCH/MENTAL HEALTH:

- Feeling depressed or anxious

### URINARY/BLADDER PROBLEMS:

- Difficulty urinating (stopping/starting)
- Menstrual irregularities
- Blood in urine

### SKIN:

- Chronic rash
- Difficulty healing skin sores

### MUSCLE/JOINT:

- Joint pain (where and when does it hurt the most)?

Joint swelling \_\_\_\_\_

- Loss of function in a joint or extremity

Joint Instability (feeling of giving way) \_\_\_\_\_

Other: \_\_\_\_\_

### NEUROLOGICAL:

- Numbness/tingling in an extremity (where and when does it occur)? \_\_\_\_\_

Loss of consciousness

Fainting episodes

Memory loss

Paralysis

Weakness in extremity

Other problems not listed \_\_\_\_\_

**Unexplained weight LOSS or GAIN (circle which one) Amount:\_\_\_\_\_**

**Unexplained:**  Fevers  Night Sweats  General weakness

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**NONE OF THE ABOVE**

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Completed by:

\_\_\_\_\_  
Patient Signature (or legal guardian)

\_\_\_\_\_  
Date