

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Referring Physician: _____

Age: _____

Family Physician: _____

CHIEF COMPLAINT: (description of your current orthopedic problem) **DATE OF INJURY/ONSET OF PAIN**: _____

HISTORY OF PRESENT ILLNESS: (please answer these questions regarding your current problem)
Where? RIGHT or LEFT? What are your symptoms? How long have you had these symptoms?

PAST MEDICAL HISTORY: (ALSO LIST ANY MEDICAL CONDITIONS FOR WHICH YOU ARE CURRENTLY BEING TREATED.)

Have you ever had the following type of "BLOOD CLOT"

DEEP VEIN THROMBOSIS (DVT): YES / NO **DATE**: _____

PULMONARY EMBOLISM: YES / NO **DATE**: _____

Surgical History (TYPE OF AND DATE):

Current Medications (PLEASE LIST DOSAGE):

Any Known Allergies (TO MEDICATIONS):

FAMILY MEDICAL HISTORY (PAST OR CURRENT MEDICAL CONDITION OF FAMILY MEMBER):

Mother: _____ Father: _____

Siblings: _____

Children: _____

SOCIAL HISTORY (PLEASE CIRCLE OR COMPLETE ALL THAT APPLY):

Single Married Widowed Divorced/Seperated
Tobacco use (packs per day): _____ Alcohol use (drinks per day): _____

REVIEW OF SYSTEMS (PLEASE CIRCLE ALL THAT APPLY):

Constitutional	Respiratory	Skin	VITALS
Fever	Tuberculosis	Infections	Temperature: _____
Weight Change	Pneumonia	Lesions/Ulcers	Pulse Rate: _____
Eyes	Endocrine	Neurological	Oximetry: _____
Visual Changes	Diabetes	Seizures	BP: _____
Ear, Nose & Mouth	Thyroid Problem	Paralysis	
Hearing Change	Gastrointestinal	Psychiatric	
Sinus Problems	Nausea/Vomiting	Depression	
Dental Problems	Blood in Stool	Hematologic	
Cardiovascular	Genitourinary	Blood Clots	
Chest Pain	Urinary infections	Bleeding Hypertension	
Incontinence			
Shortness of Breath			

PATIENT Signature: _____

Date: _____

Physician Signature: _____

Date: _____