PATIENT MEDICAL INFORMATION SHEET

NAME: _____ DOB_____

HOME PHONE _____ WORK PHONE _____ _____

Please answer the following questions to the best of your ability.

What problem brings you to the clinic? _____

Do you have pain: at night _____ at rest_____ with activity _____

What symptoms do you have: _____

_____

and when did they start: _____

Are you allergic to or had a reaction to any medications, please list the medication & reaction:

(ex: Aspirin - rash ; Tylenol - itching)_____

_____

_____

Do you have any other allergies? _____

Are you allergic to any type of chicken products? NO YES

Are you allergic to latex? NO YES If NO skip down to History section.

Have you ever had swelling, itching, hives, or other symptoms after:

contact with a balloon	NO	YES
contact with rubber products	NO	YES
contact with latex products	NO	YES

Are you allergic to bananas, avocados, kiwifruits or chestnuts? NO YES

Are you allergic to any type of shellfish? NO YES

Do you have a history of:

	NO	YES		NO	YES
Breathing problems	( )	( )	Urinary Problems	( )	( )
Heart Problems	( )	( )	Bowel Problems	( )	( )
Recent Fever	( )	( )	Vision Problems	( )	( )
Blood Pressure Problems	( )	( )	Hearing Problems	( )	( )
Diabetes	( )	( )	Do you smoke	( )	( )
Insulin	( )	( )	Quantity _____		
Oral Medication	( )	( )	Use Alcoholic Beverages	( )	( )
Diet	( )	( )	Daily	( )	( )
Arthritis	( )	( )	Recreational Substance Use	( )	( )
Mobility Problems	( )	( )	Require A Special Diet	( )	( )
Wheelchair	( )	( )	Blood Transfusion	( )	( )
Crutches/Cane	( )	( )	Seizures	( )	( )
Walker	( )	( )	Cancer	( )	( )
Ulcers	( )	( )	Are You Pregnant	( )	( )
Weight Changes	( )	( )	Menstrual Changes	( )	( )

If you answered yes to any of the above questions, please explain in the space below. Please print.

_____

_____

_____

_____

_____

_____

Dr. Signature_____ Date_____

OVER >

If you are under a doctor's care for any problems other than the one for which you are here for please explain.

_____

_____

_____

List any past serious medical problems. Give dates please. _____

_____

_____

_____

List any past major surgeries. Give dates please. _____

_____

_____

_____

_____

If you have ever had any problems with anesthesia, please explain. _____

_____

Please list all medications you are taking on a daily basis. ex:

___Asprin 81mg_____ DOSE 1Xday

_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____
_____	DOSE _____	_____	DOSE _____

List family history problems:_____

_____

_____

_____

Age _____ Ht _____ Wt _____ Marital Status S M D W

Right Hand Dominant/ Left Hand Dominant/Bilateral Occupation_____

Sports/Recreational Activities: _____

Hobbies: _____

Who completed this form? Patient ( ) Other ( ) Specify _____

Have you or anyone in your family been treated by the doctor you are seeing today? YES NO If yes, list persons name and orthopedic problem. _____

Signature_____ DATE_____