Date_____

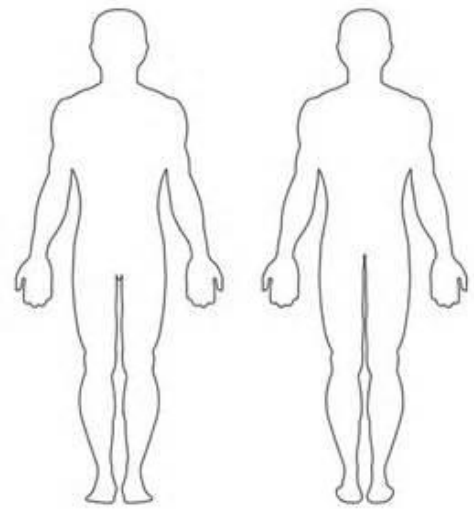
Orthopedic Specialty Associates
General Medical Information

Patient Name_____**Nickname** _____**DOB**_____**Doctor**_____

Age _____ **Height** _____ **Weight** _____ **I am:** ☐ Right Handed ☐ Left Handed ☐Ambidextrous

Mark where you are experiencing pain.

FRONT BACK



Check the boxes next to where you have **pain or problems**

☐Neck			☐Mid Back	
☐Upper Back	Right Left		☐Lower Back	
☐Shoulder Blade	Right Left		☐ Pelvis	Right Left
☐Shoulder	Right Left		☐Hip	Right Left
☐Arm	Right Left		☐Thigh	Right Left
☐Elbow	Right Left		☐Knee	Right Left
☐Forearm	Right Left		☐Leg	Right Left
☐Wrist	Right Left		☐Ankle	Right Left
☐Hand	Right Left		☐Foot	Right Left

When did your symptoms **FIRST** begin? (Date if known)_____**Pain Level** (0-10)_____

Describe how the problem or condition **FIRST** began_____

Mark an **X** in the box next to **all other orthopedic problems** for which you have had treatment, **and explain:**

If NONE mark here ☐

	Circle	**Year**	**Explain:** ***Diagnosis, tests, treatment, surgery, physician, etc.***
☐Neck			
☐Mid Back			
☐Low Back			
☐Chest Wall			
☐ Abdominal Wall			
☐Scapula	Right Left		
☐Shoulder	Right Left		
☐Elbow	Right Left		
☐Wrist/Hand	Right Left		
☐Pelvis	Right Left		
☐Hip	Right Left		
☐Thigh	Right Left		
☐Knee	Right Left		
☐Ankle/Foot	Right Left		
☐Other	Right Left		

Date_____

List All Medication Allergies ☐ None _____

List All Other Allergies ☐ None _____

List All Medications (dosage & frequency) ☐ None _____

_____

_____

List all Nutritional Supplements ☐ None _____

_____

Pharmacy Name / Number _____

Mark an **X** in the box next to **all** of the following conditions that **you** have had **and describe:**

If NONE mark here ☐

☐Diabetes	☐ Skin Disease
	☐ Muscle Disease
☐Heart Murmur or Heart Valve Disease	☐ Bone Disease
☐Heart Disease, Vascular Disease	☐ Ankylosing Spondylitis
☐Heart Attack	☐ Fracture
☐Abnormal Heart Rhythm	☐ Dislocation
☐High Blood Pressure	☐ Ligament Injury
☐ Low Blood Pressure	☐ Tendon Injury
☐ Anemia	
☐ Blood Clots (Lung or Limb)	☐ Congenital Dysplasia, Disorder or Condition
	☐ Connective Tissue Disorder (i.e. Marfans, Ehlers Danlos)
☐ Asthma	☐ Inflammatory Arthritis (i.e. Rheumatoid)
☐ Lung Disease	☐ Autoimmune Disease
	☐ Metabolic Disease
☐ Any Infectious Disease	
☐ Skin Infection (ie. MRSA)	☐ Fibromyalgia
☐ Liver Disease	☐ Complex Regional Pain Syndrome
☐ Hepatitis (ie. A, B, C, Other)	
☐ HIV AIDS	☐ Cancer
	☐ Tumor
☐ Kidney disease	
☐ Stomach Ulcer	☐ Concussion / head injury
☐ Ulcerative Colitis	☐ Severe / frequent headaches (Migraines)
☐ Crohns Disease	
☐ Thyroid disease	☐ Seizure disorder
☐ Liver Disease	Last Seizure Date
	☐ Drug or Narcotic Dependency
	☐ Alcohol Dependency

List All Other Medical Problems: _____

_____

Date_____

List <u>All Other</u> Previous Surgeries: _____

_____

Do you have or have you had **any other injuries or sport related problems** not mentioned above? ☐ No ☐ Yes

Explain_____

_____

Have you ever had a blood transfusion?	☐ No ☐ Yes	When_____
Do you have a diagnosed blood clotting disorder?	☐ No ☐ Yes	Describe_____
Do you bruise easily?	☐ No ☐ Yes	Describe_____
Do you bleed for a prolonged time period when cut?	☐ No ☐ Yes	Describe_____
Are you missing a paired organ (ie kidneys, testicles, etc.)	☐ No ☐ Yes	Describe_____

Have **<u>you</u>** or anyone in **<u>your family</u>** ever had any **complications or problems from anesthesia?** ☐ No ☐ Yes

Explain any anesthesia complications_____

Mark an **X** in the box next to **<u>all</u>** of the following conditions that a **<u>Family Member</u>** has had and **<u>explain</u>**:

If NONE mark here ☐

Condition	**Explain**
☐ Diabetes	
☐ Lung Disease	
☐ Heart Disease / Attack	
☐ Stroke	
☐ High Blood Pressure	
☐ Blood Clots	
☐ Bleeding Disorder / Anemia	
☐ Muscle Disease	
☐ Bone Disease	
☐ Osteoarthritis	
☐ Inflammatory Arthritis	
☐ Autoimmune Disease	

Do you drink beer or alcohol?	☐No ☐Yes	How often _____
Do you smoke?	☐No ☐Yes	Packs per week_____ Years?_____
Do you use smokeless tobacco?	☐No ☐Yes	Cans/bags per week_____If you use tobacco, please STOP
Have you been advised to quit?	☐No ☐Yes	Quit date_____

My signature below indicates that the above information is true and correct to the best of my knowledge.

Signed _____ **Date**_____
(Parent / Guardian for Minor)