

Arthritis and Sports Orthopaedics

Patient History

Please answer all questions.

Name: _____ Date: _____
(First, Middle, Last)

Age: _____ Birthdate: _____ How did you hear about this practice?
Height: _____ Weight: _____

Marital status: _____

Occupation: _____ Family Physician: _____

Please include first and last name

ALLERGIES: _____ Physician location: _____

Phone number: _____ Fax: _____

PRESENT MEDICATIONS (list all)

Name	Dose	Frequency	Reason
------	------	-----------	--------

Specific reason for seeing Orthopedic Surgeon: 1. _____
2. _____

Symptoms began: _____ 3. _____
4. _____

PAST MEDICAL HISTORY 5. _____
(List any medical problems) 6. _____

SOCIAL HISTORY

Do you smoke? Yes No

If yes, how much _____

Do you drink alcohol? Yes No

If yes, how much _____

Do you use drugs? Yes No

If yes, name of substance _____

REVIEW OF SYSTEMS

HAVE YOU EVER HAD:

(Circle and what year)

Heart Attack Yes No

Irregular Heartbeat Yes No

Heart Failure Yes No

Stomach Ulcers Yes No

Stroke Yes No

High Blood Pressure Yes No

Diabetes Yes No

Kidney Disease Yes No

Joint Pain Yes No

Emphysema Yes No

Hepatitis Yes No

Difficulty Urinating Yes No

Epilepsy/Seizures Yes No

Abnormal Bleeding Yes No

Anemia Yes No

Drug Reaction Yes No

Anesthetic Reaction Yes No

Cancer Yes No

FAMILY HISTORY

Heart Disease Yes No

Diabetes Yes No

Anesthetic Reaction Yes No

Cancer Yes No

Arthritis Yes No

Other: _____

PREVIOUS SURGICAL HISTORY

Procedure	Date	Complications
-----------	------	---------------

1. _____

2. _____

3. _____

4. _____

MEDICAL RECORDS RELEASE

I authorize and request the release of my medical records to:

1-Family Physician: _____ Phone _____ Fax _____

2-Other Physician: _____ Phone _____ Fax _____

List below those individuals (family, friends, interpreter, etc.) you will allow disclosure of your personal health information from Arthritis and Sports Orthopaedics as necessary during the course of your health care services:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____