## Welcome to ORTHOPAEDIC ASSOCIATES, INC.

Name: ______________________________ Today's Date: __________
Previous or Alternative Name: ______________________________
Date of Birth: __________ Social Security #: __________ Gender: □ M □ F □ Transgender
Address: ______________________________ City/State/Zip Code: ______________________________
Phone #: (H) __________ (W) __________ (C) __________ E-mail: ______________________________
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Partner □ Legally Separated
****In Case of Emergency-Notify:** __________ **Phone #:** __________ **Relationship:** __________

Primary Care Doctor: __________ City/State: __________ Phone __________
Referring Doctor: __________ City/State: __________ Phone #: __________
****PHARMACY**:** __________ Address: __________ Phone #: __________

### EMPLOYMENT INFORMATION:

Employer Name: ______________________________ Phone #: __________
Address: ______________________________ City/State/Zip Code: __________
Occupation: __________
*****IF YOUR CURRENT PROBLEM IS THE RESULT OF A WORK INJURY OR LIABILITY, PLEASE COMPLETE THE FOLLOWING:**
*Check all that apply*: □ Work Accident □ Car Accident □ Slip/Fall □ Other-cause: __________
**Date of Injury:** __________ Place First Treated: ______________________________
List any tests that were done: ______________________________

Did you report this to your employer? □ Yes □ No Date last worked: __________ Date returned to work: __________

Attorney Name: __________ Address: __________ Phone #: __________

### MEDICAL INSURANCE INFORMATION:

□ SELF PAY

***Primary*** Insurance: __________ Policy #: __________ Co-Pay: __________
Cardholder's Name: __________ Date of Birth: __________ Social Security #: __________
Employer: __________
***Secondary*** Insurance: __________ Policy #: __________ Co-Pay: __________
Cardholder's Name: __________ Date of Birth: __________ Social Security #: __________
Employer: __________

***If the insurance is in someone's else name, please complete the following:***
Name: __________ Relationship: __________
Address: __________ City/State/Zip Code: __________
Phone #: (H): __________ (W): __________ (C): __________

### CURRENT MEDICAL INFORMATION:

Why are you seeing the doctor today?: (Right knee pain, left hand numbness, etc) __________
Did you injure yourself/how injury occurred: __________ **Date of Injury:** __________
Place First Treated: __________ List any tests that were done: __________

**PRESENT MEDICAL HISTORY:** Your Height: __________ Your Weight: __________ (*office use only: HR* ______)

**CURRENT MEDICATIONS AND DOSAGES:**

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

**ALLERGIES (Medications):** ______________________________

## PAST MEDICAL HISTORY:

Have you ever had? (Please check all that apply)

- ☐ Stroke
- ☐ Seizure/epilepsy
- ☐ Migraines
- ☐ Mental Illness (depression, etc.)
- ☐ Thyroid Disease
- ☐ Heart disease/failure/attack
- ☐ Heart rhythm problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Pneumonia
- ☐ COPD/asthma/TB
- ☐ Hepatitis
- ☐ Cirrhosis of the liver
- ☐ Anemia
- ☐ AIDS
- ☐ Stomach ulcers
- ☐ GERD/stomach reflux
- ☐ Sleep apnea
- ☐ Gallstones
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Cancer (type) ____________
- ☐ Arthritis
- ☐ Gout
- ☐ Phlebitis/varicose veins/blood clot
- ☐ Substance abuse (alcohol/drugs)
- ☐ Anesthesia problems
- ☐ Other: ____________________

**Previous Surgeries:**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

**Social History:**

*Race: ☐ American Indian ☐ Alaska native ☐ Asian ☐ White ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Refuse to Report

*Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refuse to Report

Do you smoke? ______ Amount per day: _____ Alcohol use? _____ Amount per day: ______

Do you have children: ________ If yes, number/ages of children? ______________________

Who lives with you at home? ______________________________

**Family History:** Mother's Age: ________ (Living or Deceased) Father's Age: __________ (Living or Deceased)

Number of brothers/sisters and ages: ______________________________

Has anyone in your family ever had? (Please check all that apply):

- ☐ Stroke
- ☐ Heart disease
- ☐ Lung disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Arthritis at a young age
- ☐ Cancer (type) ____________
- ☐ Lupus, gout, rheumatoid arthritis
- ☐ Ulcerative colitis or Crohn's disease

## REVIEW OF SYSTEMS

Are you currently having or have you *ever* had recurrent problems with (check all that apply):

- ☐ Loss of or double vision
- ☐ Loss of hearing
- ☐ Ear pain
- ☐ Frequent nosebleeds
- ☐ Difficulty swallowing
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Severe headaches
- ☐ Unexplained weight loss
- ☐ Bleeding problems
- ☐ Chest pain/angina
- ☐ Irregular heartbeat
- ☐ Swollen ankles (both)
- ☐ Calf cramps with walking
- ☐ Nausea/vomiting
- ☐ Stomach pain or ulcers
- ☐ Bowel/bladder problems
- ☐ Fevers/chills
- ☐ Rashes
- ☐ Burning/frequent voiding
- ☐ Jaundice or liver problems
- ☐ Seizures
- ☐ Fainting/black outs
- ☐ Dizziness/balance problems
- ☐ Insomnia
- ☐ Depression/anxiety
- ☐ Night sweats
- ☐ Lyme Disease

***I understand that the answers and explanations that I have provided on these 2 pages are important for my safety during and after treatment and/or surgery, and I therefore certify that this information is true, accurate and to the best of my knowledge.***

Signed: ____________________ Print Name: ____________________ Date: __________

*(For office use only):* Reviewed: ______________________________ Date: __________