

BLAIR ORTHOPEDICS

PATIENT INFORMATION

Please Complete All Lines

Date _____

Name _____
Last First Middle

Employer (Name of Firm) _____

Address _____

Business Telephone ____ (____) _____

City State Zip Code

Occupation and Description of Job _____

Home Telephone ____ (____) _____

Cellular Telephone ____ (____) _____

Work Status: Regular Light Work Disabled

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Date Disability Began _____

Referring Physician _____

Patient's Social Security Number _____

Family Physician _____

Email Address: N/A _____

Person to Contact in an Emergency, other than spouse (please include telephone number and relationship to you) _____

Do you have a Power of Attorney? _____ If yes, please provide their name and telephone number _____

History of Current Injury/Condition

Reason for today's visit to the doctor (please specify which body part & left or right side) _____

Have you had any previous orthopedic surgeries pertaining to the current injured area? Yes No If yes, please list: _____

Have you had any previous Accidents/Injuries pertaining to the current injured area (include dates) Yes No If yes, please list: _____

If your current condition is related to an accident, when did it occur? N/A _____

Where did it happen? Home Work N/A Other please specify _____

How did it happen? N/A _____

If an accident did not occur, approximately when did your symptoms begin? N/A _____

Please list any treatment to date, pertaining to the current injured area (including hospitalization) beginning with the first treatment & approximate date. Please include any specialists seen recently (Cardiologists, etc.) N/A

Are you: Right Handed _____ or Left Handed _____? Height _____ Weight _____

PLEASE TURN OVER

PAST MEDICAL HISTORY

Please list any previous surgeries/hospitalizations (including all orthopedic surgeries) N/A _____

Please list all chronic medical conditions (i.e. heart, respiratory, kidney, etc.) N/A _____

Please list your **mother's history** of chronic medical conditions N/A _____

Please list your **father's history** of chronic medical conditions N/A _____

Are you diabetic? Yes No If yes, how do you control/manage your condition? _____

Do you have any allergies? (food, medications, etc.) Yes No If yes, please list and explain your reaction: _____

Present medications: Aspirin Plavix Coumadin

Please list all other medications: _____

Have you experienced any of the following: Please explain if yes.

Yes	No	nature of problem	comments & approximate date	Yes	No	nature of problem	comments & approximate date
___	___	recent weight loss	_____	___	___	blood clots	_____
___	___	headaches	_____	___	___	high blood pressure	_____
___	___	trouble with vision	_____	___	___	chest pain	_____
___	___	trouble with hearing	_____	___	___	respiratory problems	_____
___	___	allergies/hay fever	_____	___	___	liver disease/gallbladder	_____
___	___	asthma	_____	___	___	stomach trouble	_____
___	___	thyroid problem	_____	___	___	swelling (feet/ankles)	_____
___	___	diabetes	_____	___	___	arthritis	_____
___	___	anemia	_____	___	___	kidney disease/stones	_____
___	___	heart problems	_____	___	___	gout	_____
___	___	mitral valve prolapse	_____	___	___	bleeding tendency	_____
___	___	heart murmur	_____	___	___	scarring tendency	_____
___	___	numbness (feet/legs)	_____	___	___	joint pain or stiffness	_____
___	___	burning (feet/legs)	_____	___	___	cancer	_____
___	___	depression/anxiety	_____	___	___	stroke	_____
___	___	other illness/problems	_____				_____

Do you use any tobacco products? Yes No If yes, please explain how much: _____

Do you use alcohol? Yes No If yes, please explain how much: _____

Are you using any illegal drugs? Yes No If yes, please list name of drug and explain how much: _____

Secondary Job _____

Hobbies _____

Sports Activities _____

The documented information is true and complete to the best of my knowledge.

Signature _____

Date: _____

DATE:

NOTES: