

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_

**Chief Complaint** \_\_\_\_\_

**Right/Left (Please Circle)** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**Date of Injury** \_\_\_\_\_ (Please Circle) @ **Work/Sports/Home/Auto/No Known**  
**Litigation Yes/No**

**EMPLOYMENT STATUS:** \_\_\_ **Student** \_\_\_ **Working**  
\_\_\_ **Full-time** \_\_\_ **Part-time** \_\_\_ **Retired** \_\_\_ **Disabled**

**JOB DESCRIPTION:** \_\_\_\_\_

**SMOKING HISTORY:** \_\_\_ **Never** \_\_\_ **Previously** \_\_\_ **Packs/Day for** \_\_\_ **yrs/mos**  
**Quit** \_\_\_ **yrs/mos** \_\_\_ **Currently** \_\_\_ **Packs/Day for** \_\_\_ **yrs/mos**

**ALCOHOL:** \_\_\_ **Beers/Wine per day** \_\_\_ **oz of alcohol/day** **ADDICTING DRUGS:** \_\_\_\_\_

**ALLERGIES AND MEDICATION INTOLERANCE**

ALLERGIES	MEDICATION AND REACTION
Describe any previous adverse reactions to anesthesia or blood transfusions:	

**CURRENT MEDICATIONS AND DOSAGES (INCLUDE NON-PRESCRIPTION & HERBAL SUPPLEMENTS)**

Medication	Dose	Medication	Dose

**PAST SURGICAL HISTORY**

Surgery	Year	Surgery	Year
<b>Appendectomy, angioplasty, colonoscopy, cardiac catheterization, hysterectomy, tonsillectomy, etc.</b> (Please circle all that apply)			

<b>Fracture History:</b>				
<b>System Review</b>	<b>Circle all that apply</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
<b>Eyes, Ears</b>	Contacts, metal in eyes, cataracts, glaucoma, loss of hearing			
<b>Psychological</b>	Depression, anxiety			
<b>Respiratory</b>	Asthma, emphysema, bronchitis, shortness of breath			
<b>Cardiovascular</b>	High blood pressure, heart attack, chest pain, palpitations, blood clots, high cholesterol, swelling (lower extremities)			
<b>Gastrointestinal</b>	Abdominal pain, nausea/vomiting, constipation, diarrhea, colitis, ulcer, gall bladder, pancreatitis			
<b>Genitourinary</b>	Urinary tract infection, renal disease/failure, incontinence, sexually transmitted disease Female: pregnant, post menopausal			
<b>Endocrine</b>	Thyroid disease, diabetes			
<b>Integumentary</b>	Rash			
<b>Neurological</b>	Stroke, poliomyelitis, migraines, numbness, tingling			
<b>Musculoskeletal</b>	Joint pain, back pain, neck, sciatica, fibromyalgia, rheumatoid arthritis, osteoarthritis, lupus, osteoporosis			
<b>Hematological</b>	Hepatitis, HIV, mononucleosis, bleeding disorders    Blood Type_____			
<b>Cancer History</b>	Please List:			

**FAMILY HISTORY**

<b>Family Member</b>	<b>Living</b>	<b>Age(s)</b>	<b>Medical History</b>
Father			
Mother			
Brother(s)			
Sister(s)			

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_