PREMIER ORTHOPAEDICS & SPORTS MEDICINE, PLC

SKYLINE CARE CENTER

Steven G. McLaughlin, M.D. **L. Brett Babat, M.D.**
Steve G. Salyers, M.D. **Daniel J. Burval, M.D.**

Date: ________________________________

Patient Name: ____

If under the age of 18, please list the name of legal guardian(s): ____________ Relationship: ______________

Age: _______ Date of Birth: ______________ Marital Status: ____________ ❑ Right Handed ❑ Left Handed

Occupation: ____

Who referred you to our office? ________________________________

Primary Care Doctor: _____________________ Would you like our office notes sent to this doctor? ❑ Yes ❑ No

Hobbies / Interests: ____

MEDICATIONS

List any medications (non-prescription or alternative), vitamins, supplements, and/or natural remedies you are taking:

____

List all *prescription* medications you are currently taking:

Medications	Dose (mgs)	How Often	Date Prescribed

➡ *Note: if you need more space, please use the back of this sheet.*

ALLERGIES

What medications are you ALLERGIC to? ________________________________

Type of reaction experienced to these medications: ________________________________

What substances are you ALLERGIC to? (example: Betadine, Radiographic Dye, Adhesive Tape, etc.)

____

Type of reaction: ____

Have you had any blood transfusions? ❑ Yes ❑ No Date of transfusion: ____________________

Any previously broken bones? ❑ Yes ❑ No Which one(s)? ____________________

MEDICAL HISTORY

Hospitalizations / Operations / Illnesses	Year	Physician / Surgeon

➡ *Note: if you need more space, please use the back of this sheet.*

Patient Name: ______________________________ Date: ________________

Please mark the medical problems that you have *NOW*:

- ❑ I HAVE NO KNOWN MEDICAL PROBLEMS
- ❑ Asthma
- ❑ Arthritis
- ❑ Alcoholism
- ❑ Cancer
- ❑ Coronary Artery Disease
- ❑ Colon Polyps
- ❑ COPD, Lung Problems
- ❑ Diabetes, Childhood Onset
- ❑ Diabetes, Adult Onset
- ❑ Emphysema
- ❑ Hepatitis *Type:* ____________________
- ❑ Heart Surgery
- ❑ High Blood Pressure / Hypertension
- ❑ High Cholesterol
- ❑ Immune Disorder
- ❑ Kidney Disease
- ❑ Kidney Failure
- ❑ Kidney Stones
- ❑ Liver Disease / Liver Problems
- ❑ Nervous Breakdown *Year:* __________
- ❑ Osteomyelitis
- ❑ Overweight
- ❑ Peripheral Vascular Disease
- ❑ Seizures *Type:* ________________
- ❑ Shingles
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Ulcers
- ❑ Other: ______________________
- ❑ Other: ______________________
- ❑ Other: ______________________

TOBACCO

Do you now or have you ever used tobacco products? ❑ Yes ❑ No

If yes, what type of product? ❑ Cigarettes ❑ Chewing tobacco ❑ Snuff ❑ Other

1. I am a current smoker. I smoke ______________ packs per day.
2. I am no longer a smoker. I quit ______________ years / months / days ago. *(circle one)*

   I smoked for _____________ years / months / days. *(circle one)*

Do you now or have you ever used drugs? ❑ Yes ❑ No

Recreational / Cocaine / Marijuana / Other:______________________________

ALCOHOL *(mark all that apply)*

- ❑ 1. I do not consume alcoholic beverages.
- ❑ 2. I am a recovering alcoholic.
- ❑ 3. I drink socially.
- ❑ 4. I drink on weekends only.
- ❑ 5. I drink _______alcoholic beverages per day.

Patient Name: ____________________ Date: ____________

REVIEW OF SYMPTOMS: Have you *recently* experienced any of the following? Check all that apply.

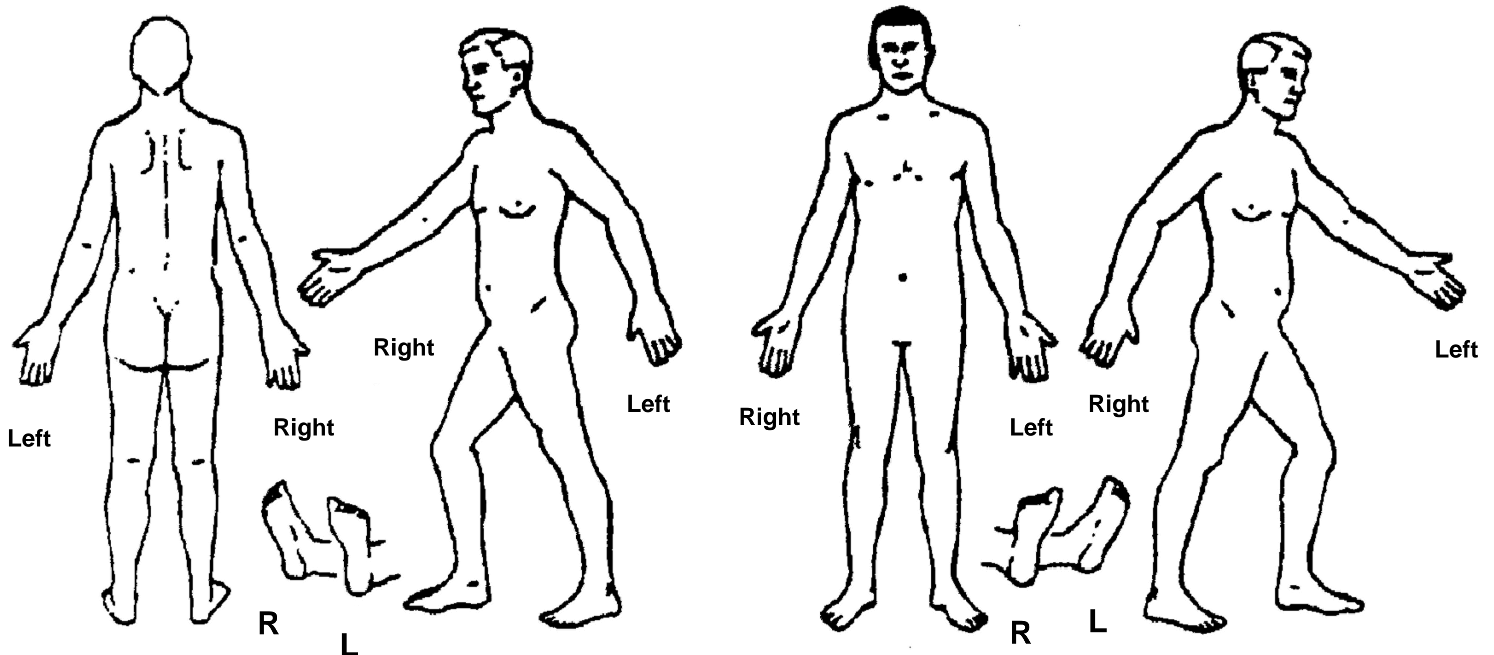
❑ Abdominal Pain / Cramping	❑ Depression	❑ Chest Pain
❑ Nausea	❑ Anxiety	❑ Heart Palpitations
❑ Vomiting	❑ Nervousness	❑ Dizziness
❑ Fecal Incontinence	❑ Loss of Appetite	❑ Leg Swelling
❑ Diarrhea	❑ Eating Disorder	❑ Need to Prop up on Shoulders to Sleep
❑ Constipation	❑ Shortness of Breath	❑ Irregular Heartbeat
❑ Bloody Urine	❑ Dry Cough	❑ Fainting
❑ Painful Urination	❑ Bloody Cough	❑ Memory Changes
❑ Urinary Incontinence	❑ Productive Cough	❑ Seizures
❑ Frequent Urination	❑ Bruising	❑ Confusion
❑ Difficulty Walking	❑ Prolonged Bleeding	❑ Headache
❑ Weakness	❑ Nose Bleeds	❑ Ear Problems *Explain*:________
❑ Painful Joints / Muscles	❑ Trouble Swallowing	❑ Hearing Problems *Explain*: ________
❑ Fever	❑ Hoarseness	❑ Vision Problems *Explain*:________
❑ Chills	❑ Nasal Congestion	❑ Tingling in Arms or Legs
❑ Weight Gain (unintentional)	❑ Mouth Sores	❑ Varicose Veins
❑ Weight Loss (unintentional)	❑ Sore Throat	❑ Difficulty Swallowing
		❑ Loss of Coordination

Please place an "X" on the line below indicating the level of your pain in the last week:

NONE ____ ***SEVERE***

Please shade in the areas of your body where you now feel your typical pain, using the appropriate symbols listed below. Be sure to include all affected areas.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
>>>>>	═══	OOOO	XXXX	////
>>>>>	═══	OOOO	XXXX	////



Patient Name: ____ Date: ____________________

FAMILY MEDICAL HISTORY

Please indicate if any blood relative, (including biological parents, grandparents, siblings, aunts, uncles , and/or children) has a history of any of the following illnesses:

	ILLNESS	FAMILY MEMBER(S)	AGE	LIVING / DECEASED
❑ Yes ❑ No	Alcoholism			
❑ Yes ❑ No	Arthritis			
❑ Yes ❑ No	Asthma			
❑ Yes ❑ No	Bleeding Tendency			
❑ Yes ❑ No	Bronchitis			
❑ Yes ❑ No	Cancer			
❑ Yes ❑ No	Colitis			
❑ Yes ❑ No	Heart Disease			
❑ Yes ❑ No	Diabetes			
❑ Yes ❑ No	High Blood Pressure / Hypertension			
❑ Yes ❑ No	Hypothyroidism			
❑ Yes ❑ No	Kidney Disease / Failure / Stones			
❑ Yes ❑ No	Leukemia			
❑ Yes ❑ No	Liver Problems			
❑ Yes ❑ No	Osteoporosis			
❑ Yes ❑ No	Seizures			
❑ Yes ❑ No	Stroke			
❑ Yes ❑ No	Thyroid Disease			
❑ Yes ❑ No	Tuberculosis			
❑ Other:				
❑ Other:				

The information contained in this medical history form is accurate to the best of my knowledge.

Patient or Legal Guardian Signature: ____

Date: ________________________________