

Patient: Last Name First M.I

**Current Medical History**

Are you currently under the care of a physician? Y N

Current Medications	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Known Medical Allergies: \_\_\_\_\_  
Any Likelihood of Current Pregnancy? Y N

**Prior Medical History**

Previous Orthopedic Injuries / Treating Physician: \_\_\_\_\_

Please Circle Conditions / Illnesses You Have Now or Have Previously Experienced:

- |               |                                 |                  |
|---------------|---------------------------------|------------------|
| Asthma        | Gout                            | Thyroid Disease  |
| Tuberculosis  | Shortness of Breath             | Vascular Disease |
| Heart Disease | Blood Clots / Bleeding Problems | Heart Attack     |
| Hepatitis     | Kidney Disease                  | Diabetes         |
| Seizures      | Cancer                          | Emphysema        |
| Hypertension  | Arthritis                       | Ulcers           |

Previous Surgeries: \_\_\_\_\_

Have you ever had any problems during past surgeries including anesthesia reaction? No Yes  
If yes, describe: \_\_\_\_\_

**Family History**

Do your parents or any siblings suffer from any of the conditions/illnesses listed above? (be specific) \_\_\_\_\_

<b>HT</b>	<b>PB</b>
<b>WT</b>	<b>P</b>

Office Use Only

\_\_\_\_\_  
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Description of Current Problem and Body Part Involved: \_\_\_\_\_  
 (please be specific as to body part- including left vs. right i.e Thumb, Sprain, Right Hip Bruise)

Is this due to an injury? (be specific) \_\_\_\_\_

**Is this injury due to an Auto Accident?** Y N If yes, Date: \_\_\_\_\_ Were you the Driver Passenger Pedestrian

Your automobile insurance company: \_\_\_\_\_

Address of your automobile insurance company: \_\_\_\_\_  
 Street City State Zip

Telephone Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

**Is this injury due to an accident at work?** Y N If yes, Date: \_\_\_\_\_ WC Claim# \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Telephone: \_\_\_\_\_

Employer Address \_\_\_\_\_  
 Street City State Zip

**If your injury is not an auto accident or related to work, where did it happen? (be specific)** \_\_\_\_\_

IN CASE OF EMERGENCY, PLEASE GIVE US A TELEPHONE CONTACT THAT IS NOT YOUR PERSONAL RESIDENCE:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

**AUTHORIZATION:** I hereby authorize the physician to furnish information to insurance carriers concerning this illness / accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date