

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

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) \_\_\_\_\_  
\_\_\_\_\_

see other side

HT	BP
WT	P

Patient: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

**Description of Current Problem and Body Part Involved:** \_\_\_\_\_

(please be specific as to body part- including left vs. right i.e. Left Thumb Sprain, Right Hip Bruise )

Is this due to an injury? Y N Date of Injury: \_\_\_\_\_ Time of Day: \_\_\_\_\_

How did you sustain your 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 Code

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 Code

**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 Number: (\_\_\_\_\_) \_\_\_\_\_

**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

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