

Name: _____

Age: _____

Primary Care/Family physician: _____

Why are you seeing the doctor today? _____

Recent injury Chronic condition Have you hurt this limb before? Yes No

Date of injury: _____ What happened? _____

Medical conditions:

Previous surgeries (and year): _____ Any history of MRSA? Yes No (Where _____)

Any previous problems with anesthesia? If so, what? _____

Allergies:
(and reactions)

Latex allergy?
 Yes No

Medications: No medications Medicine list attached

Name	Dosage	Frequency

Do you have a regular
pharmacy? If so:

Name

City

Phone #

Social History

Occupation _____ Unemployed Retired Disabled (why? _____)

Are you: Right-handed Left-handed Use both hands equally

Are you: Single Married Widowed Divorced Separated

Who lives at home with you: _____ Live alone

Do you *normally* use: cane crutches walker wheelchair

How often? All the time Most of the time Outside the house Uneven/slick ground
 Long distances Only when I hurt Don't use assistive devices

Currently smoking? Yes No How much? _____ packs per day for _____ years

Quit smoking? When _____

Average alcohol use: _____ drinks per day week month year

Previous/current illicit drug use? _____

Family History

Please mark all that applies to your immediate family

- | | | |
|--|---|----------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding problems | Other/Details: _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatoid arthritis/Lupus | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bone/joint problems | _____ |

Review of Systems:

Do you have any current/previous problems with or take medications for:

- | | | |
|--|--|---|
| <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Nose/throat problems | <input type="checkbox"/> Prostatic hypertrophy |
| <input type="checkbox"/> Obesity/overweight | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema/bronchitis/COPD | <input type="checkbox"/> Nerve problems (neuropathy) |
| <input type="checkbox"/> Cancer (type _____) | <input type="checkbox"/> Sleep apnea (CPAP? Y/N) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Osteoarthritis (normal arthritis) |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Other intestinal problems | <input type="checkbox"/> Rheumatoid arthritis/lupus
(inflammatory arthritis) |
| <input type="checkbox"/> Heart attack/coronary artery disease | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Gout/pseudogout |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Blood clots in legs (DVT) | <input type="checkbox"/> Previous surgical infection |
| <input type="checkbox"/> Arrhythmia (type? _____) | <input type="checkbox"/> Blood clots in lungs (P.E.) | <input type="checkbox"/> MRSA infection (where _____) |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety/depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney problems (nephropathy) | <input type="checkbox"/> Other psychiatric _____ |
| <input type="checkbox"/> Vision/eye problems | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hearing/ear problems | <input type="checkbox"/> Jaundice/liver failure | |
| <input type="checkbox"/> Thyroid problems (<input type="checkbox"/> high or <input type="checkbox"/> low) | <input type="checkbox"/> Frequent urinary tract infections | |

Explanation/Other:

To be completed by Nurse:

Date: Temp Pulse BP Ht Wt

Update: Temp Pulse BP

Update: Temp Pulse BP

Reviewed by: _____, M.D. Date: _____