Easton Orthopaedic Group

Welcome

Name ______________________ Date __________ Acct. # __________

Date of Birth ______________ Age ______ Height ______ Weight ______ B/P ______

Primary Care Physician ______________________ Phone Number ______________

Referral Source ______________________

Reason for today's visit ______________________

Is this due to an injury? Yes ______ No ______ If **yes**, date of injury ______________

Were you hurt at work? Yes ______ No ______ Auto Accident? Yes ______ No ______

Is litigation pending? Yes ______ No ______ If **yes**, name of Attorney ______________

Medical History (MARK ALL CURRENT AS WELL AS PREVIOUS ILLNESSES.)

Asthma Yes ______ No ______ Cardiac Problems Yes ______ No ______

High Blood Pressure Yes ______ No ______ Nature of ______________

Stroke(s) Yes ______ No ______ Diabetes Yes ______ No ______

Seizure/Convulsions Yes ______ No ______ Type I ______ Type II ______

Bleeding Tendency Yes ______ No ______ History of Ulcers Yes ______ No ______

Thyroid Disorder Yes ______ No ______ History of Cancer Yes ______ No ______

Mental Illness Yes ______ No ______ Rheumatologic Disease Yes ______ No ______

Scoliosis Yes ______ No ______ Are you Pregnant? Yes ______ No ______

Do you have any other medical conditions that affect your bones or joints? Yes ______ No ______

List all Surgeries: ______________________ Date ______

______________ Date ______ ______________ Date ______

______________ Date ______ ______________ Date ______

List all serious Illnesses/Accidents: ______________________ Date ______

______________ Date ______ ______________ Date ______

______________ Date ______ ______________ Date ______

List all Current Medications:

Name	Dose	Condition	Name	Dose	Condition

Do you have any Drug Allergies? Yes ______ No ______ If yes, please list ______________

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OVER

Family History

	Age	Major Illnesses	If deceased, cause of death
Mother	____	________________	________________
Father	____	________________	________________
Brother/Sister	____	________________	________________
Brother/Sister	____	________________	________________
Sons	____	________________	________________
Daughters	____	________________	________________

Family history of Arthritis? Yes ________ No ________ Which family member ________________ Type ________________

Social History

Marital Status Single ________________ Married________________ Widowed________________ Divorced____________

Use of Alcohol Never ________________ Rarely ________________ Moderate ______________ Daily ________________

Use of Tobacco Never________________ Previously but quit ________________ Current packs/day________________

Are you right or left handed? ________ Living Situation Alone ________ with Spouse/Family __________ ________with Friends

Hobbies and sport activities you enjoy ____

Type of work ____

Systems Review **(Did you have any of the following symptoms within the past 6 months?)**

Constitutional Symptoms		
Good general health lately	Yes	No
Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Eyes		
Wear glasses	Yes	No
Wear contact lenses	Yes	No
Blurred or double vision	Yes	No
Glaucoma	Yes	No
Ears/Nose/Mouth/Throat		
Hearing loss or ringing	Yes	No
Earaches or drainage	Yes	No
Chronic sinus problems	Yes	No
Nose bleeds	Yes	No
Bleeding gums	Yes	No
Sore throat or voice change	Yes	No
Cardiovascular		
Chest pain	Yes	No
Palpitations	Yes	No
Swelling of feet	Yes	No
Abnormal blood pressure	Yes	No
Pulmonary		
Chronic or frequent cough	Yes	No
Shortness of breath	Yes	No
Sleep apnea/disturbed breathing	Yes	No
Endocrine		
Heat or cold intolerance	Yes	No
Skin		
Rash or itching	Yes	No
Psoriasis	Yes	No

Genitourinary		
Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Kidney stones	Yes	No
Gastrointestinal		
Loss of appetite	Yes	No
Nausea or vomiting	Yes	No
Frequent diarrhea	Yes	No
Rectal bleeding	Yes	No
Abdominal pain or heartburn	Yes	No
Peptic ulcer	Yes	No
Hepatitis	Yes	No
Neurological		
Lightheaded or dizzy	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Psychiatric		
Depression	Yes	No
Memory loss or confusion	Yes	No
Insomnia	Yes	No
Nervousness	Yes	No
Hematologic/Lymphatic		
Anemia	Yes	No
Phlebitis	Yes	No
Past blood transfusion	Yes	No
Exposure to HIV	Yes	No
Musculoskeletal		
Osteoporosis	Yes	No
History of fractures	Yes	No
History of gout	Yes	No
Rheumatoid disease	Yes	No

Reviewed by Dr. ________________________ *Date* _________ *Patient's Signature* ________________________________