

Name:

## CONFIDENTIAL PATIENT PROFILE ORTHOPEDICS

Date of service:

The following information is very important to your health. Please take time to fully complete this important information. Please print in black ink or fill in on computer.

Address:							Apt/#					
City:		State:			::Zip: ht:Weight:							
Date of Birth:				Age:			_ _Heig	 ght:	Weight:			
Sex M:	F: [	SSN#:					Email	:				
Sex M: F: SSN#: Work:								(	Cell:			
Employer:				O	cupat	ion	:					
Job Physical	Functi	on: (ex: liftin	g, ben	ding)								
Emergency Contact Name:						Phone:Family Physician						
Referred by:					Fan	nily	y Physician					
Do you want	а сор	y of your rec	ords fo	orwarded to yo	ur fan	nily	physi	cian? Yes:	No:			
MEDICAL HIS	STORY	– CHIEF CON	ЛРLAIN	IT: PLEASE CHEC	K THE	ARE	A OF	YOUR CURF	RENT PROBLEM AND WHICH SIDI			
	□ Neck						WRIS	T L: 🗆	R: □			
		Jpper Back					HANI	D L: 🗆	R: □			
		Lower Back					HIP	L: 🗆	R: □			
							KNEE		R: □			
		Shoulder		R: □	_		LEG		R: 🗆			
		Arm	L: 🗆	R: □			ANKL		R:			
		Elbow	L: 🗆	R: □			F001	「	R: 🗆			
MEDICAL HISTO	ORY: PLI	EASE <b>Check</b> the	YES or I	NO box								
ls yo	ur curr	ent orthopedic	proble	m injury related?	ПΥ	es	□No	If yes- Dat	e of injury:			
						☐ Home Accident ☐ Sports Activity ☐ Other						
									EVENTS OF THIS CURRENT			
		PROBLEM)		,	•							
Yes	No				V	es	No					
163	INO					C3	NO	HEMOPHII	IA/BLEEDING			
		HEART DISEA	SE					PROBLEMS				
		DIABETES						HIGH BLOOD PRESSURE				
		MITRAL VALV	/F DROL	A DCF				CANCER	TYPE:			
			LVE PROLAPSE						LOCATION.			
		1	-					HEPATITIS/ LIVER DISEASE  ULCERS/ STOMACH PROBLEMS				
		HIV/AIDS										
		THYROID DIS				EPILEPSY/ SEIZURES						
		DEPRESSION	MENTAL DISORDER/					ASTHMA/ RESPERATORY DISEASE/TB				
		VENERAL DISEASE						1161141 6::::	LDUGGD DISEASE			
		BLOOD CLOT/DVT/PULMONARY							LDHOOD DISEASE CHICKEN POX, MEASLES)			
		EMBOLUS						(IVIUIVIPS, C	CHICKEN POA, WIEASLES)			
		CHOLESTERO	d.					Other:				



Patients Name:		DOB:							
PAST SURGICAL HISTORY:	LIST TYPES OF HISTORY								
		5							
	4								
				_					
to MEDICATIONS 2		4		None 🗆					
FAMILY MEDICAL HISTORY:	(Check any and all that app	lies to family histor	rv)						
	DIABETES: ☐ Other:_	•	• •						
	NARY EMBOLISM: \( \subseteq \text{CAN}								
DLOOD CLOTS/DVT/FOLIVIC	NART LIVIDOLISIVI CAI	veln-Type	<del></del>						
SOCIAL HISTORY	ALCOHOL USE	TOBACCO USE	WHICH BELOW						
☐ MARRIED ☐		# OF YEARS	WHICH BELOW DESCRIBES YOUR L						
SINGLE		PACKS/DAY	STYLE?	11.5					
□ DIVORCED □	<u> </u>	☐ CHEW/SNUFF	□ VERY ACTIVE						
□ WIDOW	DRINKS/DAY	RECREACTIONAL	□ ACTIVE						
DOMESTIC		DRUG USE LIST:	□ MODERATELY						
PARTNER	NEVER DRINKS		ACTIVE						
☐ CIVIL			☐ LITTLE ACTIVIT	Y					
UNION	# OF CHILDREN		☐ SEDENTARY						
□ SEPERATED □			(NONE)						
LIVES			<u> </u>						
ALONE									
DEL ((E)A) OF C\((A)ADTO\()	46 61 1 4447								
	MS: Check ANY symptoms yo	·		□None					
CONSTITUTION	☐ Fever ☐ Chills ☐ Weight Change ☐ Fatigue ☐ Headaches								
EAR/NOSE/THROAT	☐ Earaches ☐ Sinus Problems ☐ Nose Bleeds								
0.1.0.1.0.1.4.0.0.11.1.0	☐ Sore Throat			Mouth Sores					
CARDIOVASCULAR	☐ Chest Pain ☐ Heart Problem ☐ Heartbeat Changes ☐								
DECDIDATORY	□Swelling in hands & Feet								
RESPIRATORY	□ Asthma □ Wheezing □ Shortness of Breath □ Cough								
GASTROINTESTINAL	Spitting up blood								
GASTROINTESTINAL	☐ Change of bowel movements ☐ Vomiting ☐ Nausea ☐ Heartburn ☐ Loss of appetite								
GENITO-URINARY	□ Frequent Urination □ Painful Urination □ Blood in Urine □ Kidney Stones								
GENTO OMIVARI	□ Incontinence								
PSYCHIATRIC	☐ Memory Loss ☐ Confusion ☐ Depression ☐ Sleep Problems ☐								
INTEGUMENTARY	□ Skin Rash □ Lesions								
NEUROLOGICAL	☐ Skin Rash ☐ Lesions ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐								
1.20.10200.07.2	□ Stroke □ Paralysis □ Tremor □ Head Injury								
MUSCULOSKELETAL	□ Joint Pain □ Stiffness □ Weakness □ Cramps □ Muscle Pain □								
ENDOCRINE	□ Diabetes □ Thyroid Problems □ Hot or Cold Intolerance □ Hormone								
	Problems								
HEMATOLOGIC/LYMPH	☐ Easy to Bruise or Bleed ☐ A	Anemia   Transfusio	on □Swollen Glands	□None					
IMMUNOLOGIC	☐Immune Deficiency								
THE ABOVE INFORMATION IS	CORRECT and WAS FILLED OL	JT TO THE BEST OF I	MY ABILITY:	□None					
THE ABOVE IN ORIVIATION IS	COMMECT and WASTILLED OF	31 10 111E BEST OF 1	WII ADILII I.						
Patient Signature: Date:									
Parent if Minor									
I REVIEWED and DISCUSSEI	THE ABOVE INFORMATION	N WITH THE PATIE	NT:						
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