ORTHOPAEDIC CENTER, PA
17270 Red Oak Dr. Houston, TX 770902814406960 Fax: 2814406205

Patient: **DOB:** **KSF Acct #:**

General Medical History

Emergency contact name, relation & phone number(s):_____
Please give first and last name of the doctors below. If you don't know the first name, please try to give initial.
Primary care physician: _____ Referring Physician:_____
History of Present Illness (circle all that apply):
You are: R handed, L handed, Ambidextrous
WHERE are you having pain?_____
Is this a legal or third person liability case? No Yes Potential DATE Of INJURY:_____
Work Comp Motor Vehicle Accident **Where did you get hurt**? Home / School/ Work / Store/ Car
How did you get hurt?_____
Past Medical History/Conditions/Disease circle all that apply:

Anemia	Diabetes	Hypothyroidism	Poor circulation
Angina	Diabetic Foot Ulcers	Irregular heart beat	Pregnant?circle 1: Yes No
Anxiety	Dialysis	Kidney failure	Pulmonary Embolism
Asthma	Diverticulitis	Liver problems	Reflux
Bleeding Disorder	Emphysema	LMP:_____	Rheumatoid disease
Blood clot	GI bleed	Lupus	Seizures
Cancer, type/status?_____	Heart attack	Migraines	Sleep Apnea
Chronic Back Pain	Hepatitis A,B,C	Neurological disorder	Stroke
Congestive heart failure	High Blood Pressure	Dementia	Ulcers
Depression	HIV	Urinary tract infection	Other

Medications/Supplements or Over the Counter Drugs:

Name of medication	Strength/Dose	Reason for medication

Allergies to medications/medical equipment, YES or NO? If YES, list item & type of reaction it caused:

_____
_____

Surgical History:

Surgeries or Hospitalizations	Year	Complications (if any)

Medical History: Overall level of physical health is: Excellent, Very Good, Good, Fair, Poor
Immunizations up-to-date? Y or N
Have you ever had any complications from surgery? Yes No
Have you ever had any problems with anesthesia? Yes No
If yes, describe: _____

Family History
Has anyone in your family had: (circle all that apply):

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Diabetes, Heart Attack Female under age 65, Bleeding disorder, Anesthesia problem
Cancer, Rheumatoid arthritis, Osteoporosis Heart Attack Male under age 55

Social History

Marital status: circle: Single Married Divorced Separated Widowed
Children: Yes No
Do you live alone? No Yes If no, who do you live with?_____
Do you wear glasses or contacts? Yes or No, which one? _____
Occupation: _____
What kind of work?: Physical, Sedentary, Retired, Homemaker
Regular Duty Light Duty Off Work since _____Reason: _____

Risk Factors:

Current smoker? No Yes, _____# packs/day for ____years
Quit smoking? This year over 1 year ago over 5 years ago over 10 years ago
Previously smoked? _____#packs/day for _____years
History of substance/drug abuse? No Yes, What? _____
Drink alcohol? No Occasionally Frequently
Exercise? Daily Weekly Monthly Rarely Never
What type of exercise?_____

Review of systems: Are you currently having problems with:

Please circle all that apply and explain if necessary.

General health:	Fever/Chills	Fatigue	Sleep Problems
Eyes:	Blurry vision	Double vision	
Ears/Nose/Throat:	Decreased hearing	Sore throat	Ears ringing
Cardiovascular:	Chest pain	Fainting	
Respiratory:	Shortness of breath	Cough	
Gastrointestinal:	Heartburn / Constipation	Nausea/Vomiting/Diarrhea	Rectal Bleeding
Genitourinary:	Pain on urination	Incontinence	Increased frequency
Musculoskeletal:	Joint swelling	Cramps	Weakness
Dermatological:	Rash	Itching	
Neurological:	Numbness/Tingling	Loss of Balance	History of Seizures
Psychological:	Anxiety	Depression	
Endocrine:	Weight change	Thirsty all the time	
Allergy/Immunology:	Hives	Hay Fever	
Hematology:	Easy bruising Bleeding	Edema	Enlarged lymph nodes

Patient Signature: _____Date: _____
Reviewed by: _____MD Date: _____

Your pharmacy number or name and location (give cross streets if you know them

please): _____