Name: _____ Date: _____

Age: _____ Sex: M F Race: _____

PLEASE LIST YOUR CHIEF ORTHOPEDIC PROBLEM :(Example: right knee, left hip, right shoulder)

_____

_____

_____

How and when did the problem start? _____

_____

_____

Where you in an automobile accident? YES NO
Did you get hurt at Work? YES NO
Have you been treated for "this same problem" by another physician? YES NO

Have you had recent test for the problem you will be seen for today? YES NO
If Yes, Name of test, place of test and date of test **(such as MRI, CAT scan, etc.)**

_____

_____

Who is your regular doctor? _____

Who referred you to this office? _____

Major Operations: _____

_____

Serious illnesses: _____

_____

Medications (at this time) List All: _____

_____

Drug Allergies, if any: _____

_____

Family History of: (please circle) Diabetes Arthritis Heart Disease High Blood Pressure

Have you notice any of the following? Swelling of Joints? Loss of motion? Weakness?