ORTHOPAEDIC MEDICAL GROUP

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Date:______________________________

Appt. Date/Time:____ Account No.:____________________________

Patient Name:____ Social Security #:__________________________
Last *First* *M.I.*

Birthdate:_______________________ Age:________ Sex: ❑M ❑F Home Phone:_________________________________

Height:_____________________________ Weight:__________________ Cell Phone:___________________________________

Mailing Address:____

Marital Status: ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated

Employed By:____ Phone:_________________________________

Spouse or Parent:_______________________________________ Birthdate:__________ Social Security #:__________________

Employed By:____ Phone:_________________________________

Primary Care Physician:____ Phone:_________________________________

Referred By:____

Area Injured or Medical Problem:____ LEFT RIGHT (*please circle one*)

If Injury, Date of Accident:____

How did the accident occur?:____

Allergies:____

Medications Now Taking:____

Emergency Contact:____ Phone :__________________________

Insurance	Company Name	Policy Holder	Policy #	Phone
(1)____________________	______________________________	__________________	____________	___________________
(2)____________________	______________________________	__________________	____________	___________________

Do you have any attorney for this injury?:

❑YES ❑NO Name:____Phone:____________________________

PLEASE COMPLETE MEDICAL HISTORY *(OVER ➟)*

Medical History

Patient Name:____________________ Date of Birth:____________________

PLEASE MARK ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU HAVE EVER HAD:

- ❑ Diabetes____________________
- ❑ Cardiac____________________
- ❑ Hypertension____________________
- ❑ Arthritis____________________
- ❑ Epilepsy____________________
- ❑ Gout____________________
- ❑ Nervous Disorders____________________
- ❑ Ulcers____________________
- ❑ Cancer____________________
- ❑ TB____________________
- ❑ Stroke____________________
- ❑ Asthma____________________
- ❑ Kidney____________________
- ❑ Liver____________________
- ❑ Rheumatic Fever____________________
- ❑ Phlebitis____________________
- ❑ Bleeding Disorders____________________
- ❑ HIV/AIDS____________________
- ❑ Other____________________

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LIST ANY BLOOD RELATIVES WITH ANY OF THE MEDICAL CONDITIONS LISTED ABOVE:

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MARK ANY OF THE FOLLOWING SURGERIES THAT YOU HAVE HAD:

- ❑ Tonsils____________________
- ❑ Appendix____________________
- ❑ Hernia____________________
- ❑ Gallbladder____________________
- ❑ Heart____________________
- ❑ Female____________________
- ❑ Gastric____________________
- ❑ Rectal____________________
- ❑ Injuries & Fractures____________________
- ❑ Other____________________

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How much alcohol do you consume per week?____________________

How much do you smoke per day?____________________

Any past history of substance abuse?____________________

List children and ages:____________________

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Pertinent Medical History?____________________

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MUST BE COMPLETED BEFORE SEEING THE DOCTOR