Name: _____ **Today's Date:** _____

Birth date: ____/____/____ **Age:** _____ **Gender: M ☐ F ☐** **Left ☐ or Right ☐ Handed?**

Height: _____**ft** _____ **inches** **Weight:** _____ **lbs** **Are you Pregnant? Y☐ N☐**

Worker's Comp? Y☐ N☐ **Auto Accident Injury? Y☐ N☐** **Is this a legal case? Y☐ N☐**

Reason for visit: _____ **Date of Injury:** _____

Have you had X-rays for this? Y☐ N☐ If yes, where were they done? _____

ocpn

EDICAL HISTORY: Please indicate (☒) current and/or past conditions *YOU* have had:

☐ Anxiety	☐ Emphysema/COPD	☐ Kidney Problems
☐ Asthma	☐ Fibromyalgia	☐ Osteoporosis
☐ Bleeding Problems	☐ Gout	☐ Reflux/GERD
☐ Cancer (type _____)	☐ Heart Problems _____	☐ Rheumatoid Arthritis
☐ Chronic Back____ ; Neck____ Pain	☐ Hepatitis	☐ Scoliosis
☐ Degenerative/Osteoarthritis	☐ High Blood Pressure	☐ Stroke
☐ Depression	☐ High Cholesterol	☐ Thyroid Disorder
☐ Diabetes	☐ HIV	☐ Vascular Disease

Other medical problems? _____
_____

Fractures/broken bones you have had? _____

List all your prior SURGERIES:

SURGERY	YEAR	SURGERY	YEAR

List all MEDICATIONS you currently take:

MEDICATION	MEDICATION	MEDICATION

Drug Allergies: None ☐ Metal Allergy ☐ _____

Preferred Pharmacy & location _____ Phone # _____

Please Complete Next Page

ORTHOPEDIC CARE PHYSICIAN NETWORK

Please indicate (☒) major medical problems that your *FAMILY MEMBERS* (alive or deceased) have had:

☐ Cancer (type _____)	☐ Diabetes	☐ Heart Problems
☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Other: _____

YOUR social history:

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
Do you work? Y☐ N☐ Retired ☐ Type of work? _____
Use of Alcohol: Never ☐ Rarely ☐ Moderate ☐ Daily ☐ ____ drinks per day
Use of Tobacco: Never ☐ Previously, but quit ☐ Yes ☐ ____ packs per day
Use of any other recreational drugs not listed above? _____
Living Situation: Alone ☐ With spouse☐ Family☐ other☐ _____

REVIEW of SYSTEMS: Please CIRCLE symptoms you CURRENTLY have:

General: Fever / Chills / Weakness / Weight Loss / Weight Gain / Anemia / Night Sweats

HEENT: Vision Loss / Eye Pain / Eye Discharge / Hearing Loss / Ear Pain
Sore Throat / Congestion / Runny Nose / Sinus Pressure

Lungs: Shortness of Breath / Cough / Sputum / Coughing up Blood / Wheezing

Heart: Chest Pain / Palpitations / Murmur / Dizziness / Fainting Spells / Swelling Ankles

Digestive: Heartburn / Nausea / Vomiting / Abdominal Pain / Diarrhea / Constipation / Blood in Stool / Stomach Ulcer / Difficulty Swallowing

Neurologic: Headache / Numbness / Tingling / Weakness / Dizzy or Vertigo / Balance Problems

Gen/Urinary System: Trouble Urinating / Pain when Urinating / Frequency / Infections / Incontinence / Blood in Urine / Vaginal Bleeding or Discharge

Circulation: Bleeding Problems / Leg Ulcers / Peripheral Vascular Disease / Clots / Aneurysm

Musculoskeletal: Joint Pain / Muscle Pain / Back Pain / Extremity Pain / Joint Swelling

Skin: Rashes / Itching / Infections / Psoriasis / Skin Cancer (type)_____ Location_____

Mental Health: Depression / Anxiety / Mood Swings / Panic Attacks / Insomnia / History of Addiction

Thank you for taking the time to complete this form.

Patient's Signature: _____ Date: _____

Reviewed by: _____ Date: _____