Name: _____ In order to establish a complete understanding of the financial
DOB: _____
Chart:
Date: _____

#

Chief Complaint

What body part? _____

Which side? ☐ Right ☐ Left ☐ Both

Date of Injury/Onset of symptoms _____

Was this an injury? ☐ YES ☐ NO
Was this an Auto Accident? ☐ YES ☐ NO
Was this a Work Injury? ☐ YES ☐ NO
If so, was it reported? ☐ YES ☐ NO

Primary Care Physician_____

Height _____ **Weight**_____

Are you pregnant? ☐ YES ☐ NO

Latex Allergy: ☐ YES ☐ NO

Habits *(type and amount per week)*

Tobacco:_____ Alcohol_____ Caffeine_____

Recreational drugs _____ Exercise_____

Medication Allergies

Name of drug, reaction (*hives, nausea etc.)* & when noted

_____

_____

Medication, dosage & when started.

(Will provide separate sheet, if more space is needed)

_____

_____

_____

Hospitalizations, surgeries or major illnesses

(Will provide separate sheet, if more space is needed)

_____

_____

Smoking Status

☐ Current every day smoker ☐ Former smoker

☐ Current some day smoker ☐ Never smoker

☐ Smoker-current status unknown

☐ Unknown if ever smoked

Pharmacy Information

Pharmacy Name_____

Pharmacy Address _____

Pharmacy Phone Number _____

I agree that Midwest Orthopaedics, P.A may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature _____

Employer

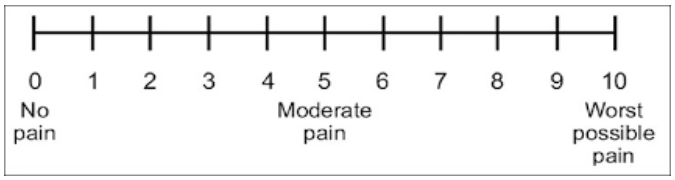
_____

Job Duties

_____

_____

Rate your pain level for this problem today



☐ Yes ☐ No HIV-AIDS
☐ Yes ☐ No Hepatitis/Liver disease
☐ Yes ☐ No Cancer/Malignancy
☐ Yes ☐ No Thyroidism (hyper or hypo)
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Angina/Heart Attack/Chest pain
☐ Yes ☐ No High____/Low___ Pressure
☐ Yes ☐ No Bursitis
☐ Yes ☐ No Emphysema/COPD
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Frequent infections
☐ Yes ☐ No Polio
☐ Yes ☐ No Phlebitis
☐ Yes ☐ No Anemia
☐ Yes ☐ No Migraines

☐ Yes ☐ No Paralysis
☐ Yes ☐ No Stomach Ulcers
☐ Yes ☐ No Recurrent Stomach Pain
☐ Yes ☐ No Neuritis/Neuralgia
☐ Yes ☐ No Pain-Stiffness in Neck/Back
☐ Yes ☐ No Asthma
☐ Yes ☐ No Weakness of Hands or Feet
☐ Yes ☐ No Tingling of Hands or Feet
☐ Yes ☐ No Meningitis
☐ Yes ☐ No Swelling/Pain in Joints
☐ Yes ☐ No Muscle Spasms
☐ Yes ☐ No Unconscious spells
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Concussions or Head injury
☐ Yes ☐ No Trembling of hands
☐ Yes ☐ No Psychiatric Condition

☐ Yes ☐ No Alcoholism/drug addiction
☐ Yes ☐ No Stroke
☐ Yes ☐ No Sciatica
☐ Yes ☐ No Rash
☐ Yes ☐ No Weight Loss/Gain
Other
(list):_____

_____