

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)

\_\_\_\_\_

\_\_\_\_\_

- 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): \_\_\_\_\_

**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**

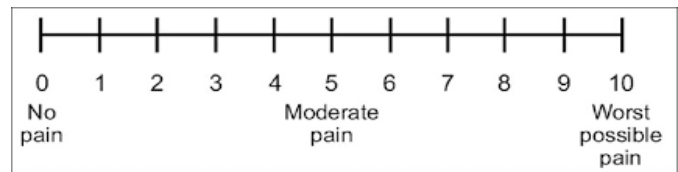
\_\_\_\_\_

**Job Duties**

\_\_\_\_\_

\_\_\_\_\_

**Rate your pain level for this problem today**



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