ORTHOPAEDIC ASSOCIATES OF GREEN BAY

DIAGNOSIS _____

Appointment Date: ____-____-____ Family MD _____ _____

Patient's Name: _____ DOB ____-____-____ Age _____

Spouse's Name: _____ Height _____

Attending School? YES NO Name of School _____ Weight _____

Sports Participation? YES NO Which Sport(s) _____

Trainer_____ PH _____ Coach: _____ PH _____

CURRENT INJURY

WHAT: _____

_____

WHEN: _____

WHERE: _____

HOW: _____

_____

TREATMENT: _____

_____

BP _____ P _____ R _____

HEALTH HISTORY OF PATIENT

HAVE YOU EVER HAD:	YES	NO
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble/Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis (DVT)		
Anemia		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
AIDS		
ANESTHESIA Problem		

Explain all YES answers:

_____

_____

_____

List all Surgeries (approximate dates):

_____

_____

_____

_____

_____

_____

_____

Current Medication and Dosage:

_____

_____

_____

_____

Are you taking birth control pills?

YES NO

Allergies to medicine:

_____

_____

_____

FAMILY HISTORY	YES	NO
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble/Stones		
Cancer		
Bleeding Disorders		
Alcoholism		

Explain YES Answers:

_____

_____

Parent's Names: _____

_____

_____

SOCIAL HISTORY

Most Recent Occupation _____

_____

_____

Married ___ Widow ___

Single ___ Divorced ___

Smoke ___ packs/day for _____ yrs.

Alchohol: Never ___ Occasional ___

Moderate ___ Heavy ___

Drugs: Overuse ___ None ___

Presently ___ Past Problem ___

COMMENTS: _____

_____

_____

REVIEW OF SYSTEMS

Have you recently had or do you now have:

	YES	NO
Reading Glasses		
Change of Vision		
Loss of Hearing		
Ear Pain		
Hoarseness		
Nosebleeds		
Difficulty Swallowing		
Morning Cough		
Shortness of Breath		
Chills or Fever		
Abnormal Heartbeat		
Swollen Ankles		
Calf Cramps Walking		
Poor Appetite		
Toothache		
Gum Trouble		
Nausea or Vomiting		
Stomach Pain		
Ulcers		
Frequent Belching		
Loose Bowels		
Blood in Stools		
Constipation		
Hemorrhoids		
Frequent Urination		
Burning on Urination		
Difficulty Starting Urination		
Difficulty Stopping Urination		
Frequent Headaches		
Blackouts		
Seizures		
Frequent Rash		
Insomnia		
Depression		
WOMEN ONLY:		
Irregular periods		
Vaginal Discharge		
Frequent Spotting		
ARE YOU OR COULD YOU BE PREGNANT?		

DIAG. CODE ___ _____

_____

_____