Diagnosis

ORTHOPAEDIC ASSOCIATES OF GREEN BAY

Appointment Date: _____/_____/_____

PERSONAL DATA

Patient Name: _____ DOB: _____ / _____ / _____ Age: _____

Emergency Contact (or Parent's Name): _____ Relationship: _____

Attending School? YES NO Which Sport(s): _____

Trainer: _____ PH: (_____) _____ Coach: _____ PH: (_____) _____

Who is Your Family Physician? _____ Who Referred You to Our Clinic? _____

CURRENT INJURY

WHAT: _____ WHEN: _____

WHERE: _____ HOW: _____

TREATMENT: _____

HEALTH HISTORY OF PATIENT: T _____ BP _____ P _____ R _____ Ht ___ ft.___ in. Wt. _____lbs.

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		
Pulmonary Embolism		
Lung Disease		
Tuberculosis		
DVT/Blood Clot		
Anemia		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
AIDS		
ANESTHESIA Problem		

Explain all YES answers:

_____

_____

_____

_____

_____

List all Surgeries and Dates:
(Use back if necessary)

_____

_____

_____

_____

_____

_____

Current Medications and Dosages:
(Use back if necessary)

_____

_____

_____

Are You Taking Birth Control Pills?

YES ❑ NO ❑

Allergies to medicine:

_____

_____

_____

FAMILY HISTORY:

	YES	NO
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Mental Illness		
Kidney Trouble/Stones		
Cancer		
Bleeding Disorders		

Explain YES Answers:

_____

_____

_____

SOCIAL HISTORY:

Employment: _____

_____

_____

Married: ❑ Widow: ❑

Single: ❑ Divorced: ❑

Smoke _____ packs/day for _____ years.

Alcohol: Never ❑ Occasional ❑

Moderate ❑ Heavy ❑

Illicit Drugs: None ❑

Presently ❑ Past Problem ❑

REVIEW OF SYSTEMS:

Have you recently had or do you now have:

	YES	NO
Claustrophobia		
Reading Glasses		
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		
Nausea or Vomiting		
Stomach Pain		
Ulcers		
Blood in Stool		
Constipation		
Hemorrhoids		
Frequent Urination		
Burning on Urination		
Difficulty Starting Urination		
Difficulty Stopping Urination		
Frequent Headaches		
Blackouts		
Seizures		
Depression		
WOMEN ONLY:		
Irregular Periods		
Are You OR Could You Be Pregnant?		

DIAG. CODE _____

_____

_____

SURGERY LIST:

Procedure	Date

MEDICATION LIST:

Medication	Dosage	Times/Day

OTHER INFORMATION