

**ORTHOPEDIC ASSOCIATES**

65 Pennsylvania Avenue  
Binghamton, NY 13903

 **PLEASE RESPOND TO EACH SECTION BELOW**

**Patient Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Reason for this Visit?** (Please describe your problem or injury) \_\_\_\_\_

**Date of injury or when problem began?** \_\_\_\_\_ Were you injured at work? Y / N

Dates out of work due to problem? \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had x-rays/diagnostic studies taken for this problem? Y / N Did you bring them with you? Y / N

Where/when were they taken? \_\_\_\_\_ Have you had a Bone Density test? Y / N

**Past Medical History** (Please check all that apply)  None apply

- |   |  |   |   |                                    |
|---|--|---|---|------------------------------------|
| <input type="checkbox"/> Heart Disease / Murmur   | <input type="checkbox"/> Lung disease            | <input type="checkbox"/> Liver disease  | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Stroke    |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Blood disorder/anemia   | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Blood clots / Phlebitis | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Cancer    |

Other: \_\_\_\_\_

**ALLERGIES:**  None  Yes, please list \_\_\_\_\_

**MEDICATIONS**  None  Yes, please list

dosage times / day

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PREVIOUS SURGERIES**  None  Yes, please list

year

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History**

Do you smoke? Y / N How many years? \_\_\_\_\_ How much / day? \_\_\_\_\_

Do you use alcohol? Y / N How much? \_\_\_\_\_ How often? \_\_\_\_\_

What is your dominant hand? Right \_\_\_\_\_ Left \_\_\_\_\_ Ambidextrous \_\_\_\_\_

Please describe your current job and its duties. \_\_\_\_\_

**Review of Systems** (Do you have problems with any of the following? Please check all that apply.)  None apply

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Urinary problems                 | <input type="checkbox"/> Swelling in feet or ankles |
| <input type="checkbox"/> Vision changes      | <input type="checkbox"/> Constipation / Diarrhea          | <input type="checkbox"/> Fever / Chills             |
| <input type="checkbox"/> Cough / Sore throat | <input type="checkbox"/> Chest pain / pressure            | <input type="checkbox"/> Numbness in hands / feet   |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Unintentional weight loss / gain | <input type="checkbox"/> Varicose Veins             |

**Family History**  None apply or list: family member family member

High Blood Pressure	Y / N _____	Diabetes	Y / N _____
Heart Disease	Y / N _____	Cancer	Y / N _____
Anesthesia Reaction	Y / N _____	Arthritis	Y / N _____
Mental Illness	Y / N _____	Stroke	Y / N _____

**I attest that this information provided is true and correct to the best of my knowledge.**

\_\_\_\_\_  
Patient Name (please print) Date

\_\_\_\_\_  
Signature of Patient / Parent / Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date