PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT: ____

ORTHOPEDIC ASSOCIATES

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☐ **Michael McClure, M.D.**	☐ **David Ellison, M.D.**		☐ **Jonathan Gdovin, RPA-C**

Patient Name: ______________________________________Date of Birth: __________________ Date: _______________

PERSONAL MEDICAL HISTORY (Please check all that apply & explain below.)

☐ Diabetes	☐ Asthma	☐ Hepatitis
☐ High Blood Pressure	☐ Emphysema / COPD	☐ Liver disease
☐ Heart Attack	☐ Stroke	☐ Kidney disease
☐ Coronary Artery Disease	☐ Seizure disorder	☐ Thyroid disease
☐ Irregular Heart Beat or Murmur	☐ Depression	☐ Skin disorders
☐ Congestive Heart Failure	☐ Nervous tendencies	☐ Osteoarthritis
☐ High cholesterol / triglycerides	☐ Parkinson's disease	☐ Rheumatoid Arthritis
☐ Bleeding disorder	☐ Heartburn / Reflux	☐ Anesthesia reactions
☐ Blood clots / Phlebitis	☐ Ulcers / Colitis	☐ Osteoporosis
☐ History of blood transfusions	☐ Enlarged Prostate	☐ Cancer ____________________
☐ Anemia	☐ Gynecologic problems	______________________________

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PAST SURGICAL HISTORY (Please list all previous surgery and dates performed.)

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MEDICATIONS (Name, strength, dosage & reason.)

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ALLERGIES (Please list medication and reaction.) Latex allergy? Y or N Reaction: _________________

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SOCIAL HISTORY

Age: _______ Occupation? ___________________________________ Do you live alone? Y or N

Tobacco Use (amount & how long?) ____________________________ Do you wear glasses or contacts? Y or N

Alcohol Use (amount & how often?) ____________________________ Do you wear dentures or partials? Y or N

(Continued on Back)

Patient Name: ____________________ Date of Birth: __________ Today's Date: __________

FAMILY MEDICAL HISTORY **(Please mark all that apply by listing appropriate family member(s).)**

High Blood Pressure: ____________________ Mental Illness: ____________________

Heart Disease: ____________________ Cancer: ____________________

Diabetes: ____________________ Arthritis: ____________________

Stroke: ____________________ Anesthesia Reaction: ____________________

REVIEW OF SYSTEMS **(Have you had any recent changes/problems with the following? If yes, explain.)**

Headaches____________________ Bowel / Bladder ____________________

Vision changes ____________________ Swelling in feet or ankles ____________________

Hearing / Nose / Throat ____________________ Constipation / Diarrhea____________________

Cough / Shortness of Breath ____________________ Hormonal ____________________

Chest pain / Heart ____________________ Significant weight loss / gain ____________________

Fever / Chills ____________________ Neurological ____________________

FEMALE PATIENTS

When was your last menstruation cycle? ______________ Is there a possibility you maybe pregnant? Y or N

When was your last Pap smear? ______________ Last mammogram / breast exam?______________

I attest that the information on this form is true to the best of my knowledge.

Patient/Parent/Guardian Signature: ____________________ ***Date:*** __________

(For office use only) ****

HPI:____________________

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PHYSICAL EXAMINATION Height: __________Weight: __________ BP: __________ Pulse: __________

General Assessment ____________________

HEENT____________________

Neck____________________

Heart ____________________

Lungs ____________________

Abdomen ____________________

Extremities ____________________

Spine ____________________

Skin ____________________

Neuro ____________________

Assessment: ____________________

Plan:____________________

____

I attest that the risk, benefits and alternatives to this procedure have been discussed with the patient and/or family.

Provider(s) Signature: ____________________ Date: __________