Patient Name____ Date of Birth ________________

Welcome to Central Montgomery Orthopedics
To help us provide the best care, please provide the following information

What is the reason for your visit today? ____

When did your symptoms begin? ____

Section 1. What Medications are you currently taking?

☐ NONE

☐ Check this box if you are giving us a copy of your medication list, then skip to section 2;
Otherwise, please complete the chart below.

Name of Medication	Dose	How do you take the medication?	How many times per day do you take the medicine?
		☐Pill ☐Injection ☐Other: _____________	☐Once ☐Twice ☐Other: _____________
		☐Pill ☐Injection ☐Other: _____________	☐Once ☐Twice ☐Other: _____________
		☐Pill ☐Injection ☐Other: _____________	☐Once ☐Twice ☐Other: _____________
		☐Pill ☐Injection ☐Other: _____________	☐Once ☐Twice ☐Other: _____________

(If you need additional space for Section 1, please check here ☐ then continue on the back of this page.)

Section 2. Do you have any Allergies? ☐ No known allergies

Drug or Substance Allergic To	Type of Allergic Reaction
	☐ Rash ☐ Nausea/Vomiting ☐Anaphylaxis ☐ Other _____________
	☐ Rash ☐ Nausea/Vomiting ☐Anaphylaxis ☐ Other _____________
	☐ Rash ☐ Nausea/Vomiting ☐Anaphylaxis ☐ Other _____________

(If you need additional space for Section 2, please check here ☐ then continue on the back of this page.)

Section 3. Tobacco and Alcohol History

Smoking/Tobacco	☐ Never smoked/used tobacco ☐ Former smoker, date stopped smoking __________ ☐ Current smoker ______packs per day
Alcohol	☐ No ☐ Yes, # of alcoholic beverages per week _________ ☐ Beer ☐Wine ☐Liquor

Section 4. Review of Systems

In the past 12 months, have you experienced any of the following?

Eyes	☐ No Problems	or	☐ Vision changes		☐ Other: __________________
ENT	☐ No Problems	or	☐ Loss of taste or smell		☐ Other: __________________
Endocrine	☐ No Problems	or	☐ Excessive thirst		☐ Other: __________________
Resp	☐ No Problems	or	☐ Shortness of breath		☐ Other: __________________
Cardiac	☐ No Problems	or	☐ Chest pain/pressure		☐ Other: __________________
GI	☐ No Problems	or	☐ Stomach ulcer	☐ Heartburn	☐ Other: __________________
Hematology	☐ No Problems	or	☐ Excessive bleeding	☐ Blot clots	☐ Other: __________________
GU	☐ No Problems	or	☐ Difficult or painful urination		☐ Other: __________________
Skin	☐ No Problems	or	☐ Non-healing sores		☐ Other: __________________
Neuro	☐ No Problems	or	Numb/tingly ☐ hands or	☐ feet	☐ Other: __________________

Patient Name____ Date of Birth ________________

Section 5. Past Medical History.
Have you been diagnosed with any of the following medical conditions?
☐ No Medical Conditions

Medical Condition	Yes
Blood clots (DVT or PE)	
Bleeding disorder (such as hemophilia or von Willebrand's)	
Heart disease	
Heart attack	
Stroke	
Mini-stroke (also called TIA)	
Peripheral vascular disease (PVD)	
Asthma	
COPD or emphysema	
Diabetes, insulin dependent	
Diabetes, non-insulin dependent	
Osteopenia	
Osteoporosis	
Sleep Apnea	
Methicillin-resistant Staph aureus (MRSA)	

If you have any other medical conditions not listed above, please describe here:
____
____
____

Section 6. Past Surgical History
Have you had any surgery in the past?
☐ No Past Surgeries

Date of surgery	Type of surgery

Section 7. Family History
Are there any medical conditions that run in your family?
☐ No family history of medical conditions

Condition	Family Member
Heart attack	☐Mom ☐Dad
Stroke	☐Mom ☐Dad
Diabetes	☐Mom ☐Dad
Cancer	☐Mom ☐Dad
Blood clots	☐Mom ☐Dad
Excess bleeding	☐Mom ☐Dad

Other family history: ________________________
____
____

Section 8. Height and Weight
What is your weight? __________ pounds
What is your height? ______ feet ______ inches

Section 9. Occupation
What is your occupation? ______________________________
Are you right-handed or left-handed (circle your response)? RIGHT LEFT

Section 10. Patient Attestation
The information on this form is accurate and complete to the best of my knowledge.

____________________________________ ______________
Signature of Patient (or Patient Representative) Date

Space below for Central Montgomery Orthopedics office use only:
☐ ROS/PSFH Reviewed

Physician Signature ________________________________ Date ___________