

Patient Name _____ Date of birth _____

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

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?
		<input type="checkbox"/> Pill <input type="checkbox"/> Injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Pill <input type="checkbox"/> Injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Pill <input type="checkbox"/> Injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Pill <input type="checkbox"/> Injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Pill <input type="checkbox"/> Injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> 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
	<input type="checkbox"/> Rash <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other _____
	<input type="checkbox"/> Rash <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other _____
	<input type="checkbox"/> Rash <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> 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	<input type="checkbox"/> Never smoked/used tobacco <input type="checkbox"/> Former smoker, date stopped smoking _____
	<input type="checkbox"/> Current smoker _____ packs per day
Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes, # of alcoholic beverages per week _____ <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor

Section 4. Review of Systems

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

- | | | | |
|-------------------|--------------------------------------|---|---------------------------------------|
| Eyes | <input type="checkbox"/> No Problems | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Other: _____ |
| ENT | <input type="checkbox"/> No Problems | <input type="checkbox"/> Loss of taste or smell | <input type="checkbox"/> Other: _____ |
| Endocrine | <input type="checkbox"/> No Problems | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Other: _____ |
| Resp | <input type="checkbox"/> No Problems | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other: _____ |
| Cardiac | <input type="checkbox"/> No Problems | <input type="checkbox"/> Chest pain/pressure | <input type="checkbox"/> Other: _____ |
| GI | <input type="checkbox"/> No Problems | <input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Heartburn | <input type="checkbox"/> Other: _____ |
| Hematology | <input type="checkbox"/> No Problems | <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Blot clots | <input type="checkbox"/> Other: _____ |
| GU | <input type="checkbox"/> No Problems | <input type="checkbox"/> Difficult or painful urination | <input type="checkbox"/> Other: _____ |
| Skin | <input type="checkbox"/> No Problems | <input type="checkbox"/> Non-healing sores | <input type="checkbox"/> Other: _____ |
| Neuro | <input type="checkbox"/> No Problems | <input type="checkbox"/> Numbness/tingling in hands or feet | <input type="checkbox"/> Other: _____ |

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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	

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

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.

Patient Signature

Date

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	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Sibling
Stroke	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Sibling
Diabetes	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Sibling
Cancer	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Sibling
Blood clots	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Sibling
Excess bleeding	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Sibling

Other family history: _____

Space below for Central Montgomery Orthopedics office use only:

ROS/PSFH Reviewed

Physician Signature _____ Date _____