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? |
|  |  | 🞏Pill 🞏Injection  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏Once 🞏Twice  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | 🞏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 | 🞏 Vision changes | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ENT** | 🞏 No Problems | 🞏 Loss of taste or smell | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Endocrine** | 🞏 No Problems | 🞏 Excessive thirst | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Resp** | 🞏 No Problems | 🞏 Shortness of breath | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Cardiac** | 🞏 No Problems | 🞏 Chest pain/pressure | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **GI** | 🞏 No Problems | 🞏 Stomach ulcer 🞏 Heartburn | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hematology** | 🞏 No Problems | 🞏 Excessive bleeding 🞏 Blot clots | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **GU** | 🞏 No Problems | 🞏 Difficult or painful urination | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Skin** | 🞏 No Problems | 🞏 Non-healing sores | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Neuro** | 🞏 No Problems | 🞏 Numbness/tingling in hands or feet | 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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 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 🞏Sibling |
| Stroke | 🞏Mom 🞏Dad 🞏Sibling |
| Diabetes | 🞏Mom 🞏Dad 🞏Sibling |
| Cancer | 🞏Mom 🞏Dad 🞏Sibling |
| Blood clots | 🞏Mom 🞏Dad 🞏Sibling |
| Excess bleeding | 🞏Mom 🞏Dad 🞏Sibling |

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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

Space below for Central Montgomery Orthopedics office use only:

🞏 ROS/PSFH Reviewed

Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_