INTERNAL ACCT# _____

PREMIER ORTHOPEDICS, PC

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Referral Source: _____ Primary Care Physician: _____

Reason for today's visit: _____

Is the visit due to an injury? Yes _____ No _____ How did the injury occur? (please be detailed) _____

_____

Workers Compensation claim? Yes _____ No _____ Motor vehicle accident? Yes _____ No _____

~ ALLERGIES ~

List all allergies (or provide a list): _____

~ CURRENT MEDICATIONS ~

List all current medications with medication name, dosage, and condition (or provide a list):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list the name of your primary pharmacy where you purchase MOST of your medications even if you use multiple pharmacies:

Name (i.e. CVS, Walgreens): _____ Street Address: _____ City, State: _____

Do you give Premier Orthopedics permission to access your current electronic medication history to verify drug names and dosages? ☐ Yes ☐ No

~ PAST MEDICAL HISTORY ~

Vaccinations: Have you ever had the Pneumonia vaccination? ☐ Yes ☐ No Have you had the Flu shot this flu season? ☐ Yes ☐ No

Have you or a family member ever had any of the following:

	Patient		Family Member			Patient		Family Member	
	Yes	*No*	*Yes*	*No*		*Yes*	*No*	*Yes*	*No*
Diabetes	☐	☐	☐	☐	Frequent Kidney Infections	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	Kidney stones	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	Kidney Failure	☐	☐	☐	☐
Blackouts / Seizures	☐	☐	☐	☐	Frequent Heartburn	☐	☐	☐	☐
Dizzy Spells / Vertigo	☐	☐	☐	☐	Stomach Ulcer	☐	☐	☐	☐
Chest Pains	☐	☐	☐	☐	Gall bladder disease	☐	☐	☐	☐
Irregular heart rate	☐	☐	☐	☐	Pancreatitis	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	Ulcerative Colitis / Crohn's Disease	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	Diverticulitis	☐	☐	☐	☐
Heart murmur	☐	☐	☐	☐	Liver Disease	☐	☐	☐	☐
Heart surgery	☐	☐	☐	☐	Hepatitis A, B, or C	☐	☐	☐	☐
Stroke / CVA	☐	☐	☐	☐	Gout	☐	☐	☐	☐
TIA's (transient ischemic attacks)	☐	☐	☐	☐	Lupus	☐	☐	☐	☐
Blockage of blood vessels: neck	☐	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	☐
Blockage of blood vessels: legs	☐	☐	☐	☐	Osteoarthritis	☐	☐	☐	☐
Asthma / Emphysema	☐	☐	☐	☐	Psoriasis	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	Cancer	☐	☐	☐	☐
Fractures / Dislocations	☐	☐	☐	☐	HIV	☐	☐	☐	☐
					Are you Pregnant?	☐	☐		

~ PAST SURGICAL HISTORY ~

List *ALL* previous surgeries: _____ _____ _____

_____ _____ _____ _____

List any other medical history you think is important and we should know: _____

_____

~ Social History ~

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Living Situation:** ☐ Alone ☐ Spouse or Family ☐ Friends

Employed: ☐ Yes ☐ No ☐ Full Time ☐ Part Time Type of Work: _____ **Disabled:** ☐ Yes ☐ No

Student: ☐ Yes ☐ No Grade: _____ School: _____

Are you: ☐ Right handed ☐ Left Handed Hobbies, Sports, Activities you enjoy: _____

Tobacco usage: ☐ Every day ☐ Some days ☐ Quit ☐ Never Year started use: _____ Year you quit: _____

Which type / How much: ☐ Cigarettes / Packs per day _____ ☐ Cigars / Number per week ☐ Smokeless / Amount per day _____

Exposed to second hand smoke? ☐ Yes ☐ No **Use illegal substances?** ☐ Yes ☐ No Type: _____ Frequency: _____

Alcoholic beverages: ☐ Yes ☐ No Type: ☐ Beer ☐ Wine ☐ Liquor - Type: _____ Number of drinks per day: _____

Colonoscopy: Have you ever had a colonoscopy? ☐ Yes ☐ No If yes, when was it last performed? _____ / _____ (Month / Year)

Results: ☐ Normal ☐ Abnormal _____

~ Review of Systems ~

Constitutional Symptoms

Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

Eyes and Vision

Wears glasses	☐ Yes	☐ No
Wears Contact lenses	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Ears / None / Mouth / Throat

Hearing loss or ringing	☐ Yes	☐ No
Earaches or drainage	☐ Yes	☐ No
Chronic sinus problems	☐ Yes	☐ No
Frequent nose bleeds	☐ Yes	☐ No
Sore throat or voice change	☐ Yes	☐ No

Cardiovascular

Chest pain	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Swelling of:		
hands, ankles, feet	☐ Yes	☐ No
Abnormal blood pressure	☐ Yes	☐ No

Pulmonary

Chronic or frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sleep apnea/disturbed sleep	☐ Yes	☐ No

Endocrine

Heat or cold intolerance	☐ Yes	☐ No

Skin

Persistent rash or itching	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No

Genitourinary

Frequent urination	☐ Yes	☐ No
Burning or painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No

Gastrointestinal

Loss of appetite	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Frequent diarrhea	☐ Yes	☐ No
Rectal bleeding	☐ Yes	☐ No
Abdominal pain or heartburn	☐ Yes	☐ No
Peptic ulcer	☐ Yes	☐ No
Hepatitis A, B, or C	☐ Yes	☐ No

Neurological

Light headed or dizzy	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No

Psychiatric

Depression	☐ Yes	☐ No
Memory loss or confusion	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No

Hematologic / Lymphatic

Anemia	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Past blood transfusion	☐ Yes	☐ No
Exposure to HIV	☐ Yes	☐ No

Musculoskeletal

Osteoporosis	☐ Yes	☐ No
History of fractures	☐ Yes	☐ No
History of arthritis	☐ Yes	☐ No
Rheumatoid Disease	☐ Yes	☐ No
History of gout	☐ Yes	☐ No