Physicians initials _____

ATLANTIC ORTHOPAEDICS - Initial Patient Medical History

Name:	Date:	SSN:	Patient ID:
Date of Birth:	Age:	Height:	Weight:	Sex: M [ ] F [ ]
Employer:	Job Title:	How long have you worked there?
Date of Accident:	When did your pain start?	SIde of discomfort/problem [ ] left [ ] right [ ] midline
Family/Medical Doctor:	Referred by:

Reason for **today's** visit: _____

Have you ever injured this area before? _____

How were you hurt? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

MEDICAL HISTORY: At any time have you had:

[ ] diabetes
[ ] stroke
[ ] seizures
[ ] glaucoma
[ ] ear, nose, throat or mouth problem
[ ] thyroid trouble
[ ] lung/breathing problem
[ ] heart problem
[ ] high blood pressure

[ ] breast disease/cancer
[ ] stomach ulcers
[ ] liver disease/hepatitis
[ ] pancreatitis
[ ] gallstones
[ ] bowel/intestinal problem
[ ] kidney disease/stones
[ ] prostate disease
[ ] gynecologic disease

[ ] anemia
[ ] bleeding disorder
[ ] blood clots
[ ] cancer
[ ] HIV/AIDS
[ ] blood transfusion
[ ] skin disease
[ ] mental health disorder
[ ] drug/alcohol abuse

[ ] other (please explain): _____

In the past 6 months have you had?

[ ]repeated fevers
[ ] weight loss
[ ] vision problem
[ ] hearing difficulty
[ ] sinus/allergy problems
[ ] shortness of breath

[ ] irregular heartbeat/palpitations
[ ] heartburn
[ ] diarrhea
[ ] painful/frequent urination
[ ] joint pain
[ ] skin rash

[ ] blackouts
[ ] depression/anxiety
[ ] low energy level
[ ] chest pain
[ ] fatigue
[ ] tingling/numbness

LIST PREVIOUS SURGERIES	YEAR OF SURGERY

-OVER-

Physicians initials _____

ATLANTIC ORTHOPAEDICS - Initial Patient Medical History (cont.)

List current medications	Dose	How often?

List drug allergies	Allergic Reaction

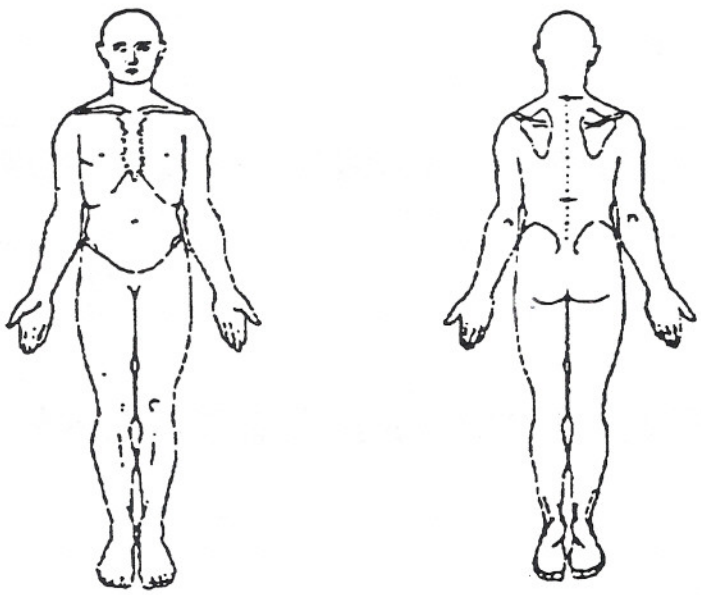
FAMILY HISTORY: Have any of your relatives had:

[ ] diabetes [ ] rheumatoid arthritis [ ] high blood pressure
[ ] cancer [ ] heart disease [ ] neck or back problems
[ ] other (explain): _____

SOCIAL HISTORY:

Marital Status: [ ] married [ ] single [ ] divorced [ ] widowed
Do you have children? [ ] no [ ] yes how many? _____
Work Status: [ ] employed [ ] homemaker [ ] retired [ ] unemployed [ ] disabled
Occupation: _____
Worker's Compensation claim for today's problem: [ ] yes [ ] no
Current Smoker? [ ] no [ ] yes packs/day _____ years _____
Former Smoker? [ ] no [ ] yes year quit _____
Alcohol use: [ ] never or rarely [ ] once a day [ ] once a week [ ] once a month
Hobbies/sports/interests: _____
Regular exercise: [ ] none [ ] occasionally [ ] regular
Type of exercise (explain): _____

Please mark the following diagrams to indicate where your discomfort is



PAIN SCALE
(indicate your level of pain)

1 (low)
|
|
|
|
|
|
|
|
|
10 (high)

Are you: [ ] RIGHT or [ ] LEFT handed