ORTHOPEDIC ASSOCIATES OF LAKE COUNTY

PATIENT INFORMATION

Patient Name Date

Family Physician Phone #

Would you like a copy of your office note sent to your family physician? Yes No

REASON FOR VISIT

Date of onset symptoms:_____ Referred by:_____

Description (Please give details)

Previous treatment for this problem: ☐ ER ☐ Urgent Care ☐ X-rays ☐ MRI ☐ Physical Therapy
☐ Family Physician ☐ Other_____

Are you currently off work for this problem: YES NO If yes, please give last date worked:

PATIENT HEALTH HISTORY

Allergies: Height: Weight:

Current Medications with Strength and Frequency, please include any over-the-counter medications or supplements

1)	5)	9)
2)	6)	10)
3)	7)	11)
4)	8)	12)

Do you use tobacco?	Do you use alcohol?	Have you used any other drug or substance in the last 12 months?
○ Never ○ Current ○ Former	○ No ○ Socially ○ Daily	○ No ○ Yes If yes, list name, and amount _____

MEDICAL PROBLEMS

_____ Heart
_____ Ulcers
_____ Asthma
_____ Diabetes
_____ Hepatitis
_____ Blood Pressure
_____ Blood Disorders
_____ Other
_____
_____

FAMILY HEALTH HISTORY

Please list any significant diseases or cause of death

Father _____
Mother _____
Brother _____
Sister _____
Spouse _____
Other _____

PAST SURGICAL PROCEDURES

Please list Date & Procedure

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

(favorite hobbies/activities)

_____
_____
_____

NATURE OF WORK JOB DESCRIPTION

(sitting, standing, walking)

_____
_____
_____