

This box is for filing purposes. Please print in color if possible.



Elizabethtown Orthopaedic Associates, P.S.C.

Name: _____ Date: _____
FIRST LAST MI MONTH DAY YEAR

Date of Birth: _____ Male Female

INJURY/ILLNESS PRESENTATION

Reason for Visit: New Illness/Pain/Injury Recurrent Illness/Injury Follow-Up Visit
 Sports Injury On-the-Job Injury Motor Vehicle Accident Second Opinion
 Other _____

Approximate Date of Onset: _____ Area(s) of Body Affected: _____
MONTH DAY YEAR

Are you: Right-Handed Left-Handed

How Injury Occurred: _____

Please Rate the Severity of Your Pain: 1 2 3 4 5 6 7 8 9 10
MILD MODERATE SEVERE

Have you been treated by another physician for this problem before? Yes No

If "Yes", name of physician: _____

List any tests you have had relating to injury: _____

Have you experienced any of the following symptoms recently:

- Blood in Stool Blood in Urine Chest Pain
 Loss of Consciousness Painful, Swollen Joints Shortness of Breath
 Weakness Other _____

PAST MEDICAL HISTORY

Have you had previous surgeries? Yes No

SURGERY

DATE

If "Yes", please list:

DOCTOR

Do you have any drug or other (e.g. chemicals, latex, plant) allergies? Yes No If "Yes", please list:

Are you currently taking any medications? Yes No

MEDICATION

AMOUNT/FREQUENCY

If "Yes", please list:

REASON FOR TAKING

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Do you have a history of (please check all that apply):

- Arthritis
- Asthma/Emphysema
- Born with Abnormality _____
- Bronchitis
- Cancer
- Cataracts
- Diabetes
- Epilepsy/Seizures
- Female Problems
- Heart Disease
- Heart Murmur
- Hiatal Hernia
- High Blood Pressure
- Histoplasmosis
- H.I.V.
- Kidney/Bladder Disease
- Liver Disease
- Lung Disease
- Skin Disease
- Stomach/Bowel Disease
- Stomach Ulcers
- Stroke
- Tuberculosis
- Other _____

Should your condition require the physician to prescribe certain diagnostic tests, the following information is necessary to determine the appropriate procedure:

Are you or could you be pregnant? Yes No

Are you claustrophobic (fear of being in small, closed areas)? Yes No

Do you have Pacemaker Neurostimulator Heart Valves Surgical Clips Artificial Joints/Limbs
 Other metal objects in your body _____

Have you had any eye (i.e. artificial eye) or ear (i.e. inner ear implant) surgery? Yes No

SOCIAL/FAMILY HISTORY

Are you currently: Unemployed Homemaker Retired Working Student Other _____

Occupation: _____ **Employer** _____

Are you: Single Married Widowed Divorced **How many children do you have?** _____

With whom do you live? Spouse Parents Children Nursing/Retirement Home Alone Other _____

Do you smoke? Yes No **Packs per Day:** _____ **Number of Years:** _____

Do you drink? Yes No **Drinks per Day:** _____ **Number of Years:** _____

Is your mother living? Yes No **Current Age or Age at Death:** _____

Illnesses mother has been treated for: _____

If deceased, cause of death: _____

Is your father living? Yes No **Current Age or Age at Death:** _____

Illnesses father has been treated for: _____

If deceased, cause of death: _____

Who are your other physicians?

Who may we thank for referring you to our office? _____