ORTHOPEDIC & SPINE SURGERY ASSOCIATES, LTD.

MEDICAL HISTORY

Date: ______________

Patient's Name: ______________________________ Age: ______________

Reason for visit: ______________________________

______________________________ Right/Left: ______________

Date of Injury/Accident or approximate date of onset: ______________________________

If Injury/Accident, please explain how it happened: ______________________________

Where did accident happen? ______________________________

Were X-rays taken? ______________ When and where: ______________________________

Did you bring them with you? ______________________________

Have you been here before? ______________________________

Family Physician ______________________________ Phone ______________

Height __________ Weight __________ Male __________ Female __________

Do you have or have you ever had: (Check all that apply)

____ Lung Trouble	____ Angina (chest pain)	____ Easy Bruising	____ Tuberculosis
____ Heart Trouble	____ Epilepsy	____ Chronic Cough	____ Hay Fever
____ Kidney or Bladder Trouble	____ Diabetes	____ Anemia	____ Heart Murmur
____ Cancer	____ Hypertension (high blood pressure)	____ Stroke	____ Asthma
____ Hepatitis, Jaundice Or Liver Disease		____ Other	____ Ulcers

Are you allergic to any medications (Penicillin, Sulfa, etc.)? ______________________________

____

Are you now taking any medications, either prescription or over-the-counter? ______________________________

____

Please list any previous surgery: ______________________________

____

If you are here because of an accident, is there a lawsuit pending as a result of the above accident/injury? ______________

Please give your lawyer's name, address and phone number: ______________________________

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If female, are you pregnant? ______________ Do you smoke cigarrettes? ______________

Who referred you to this office? ______________________________