aos albracht
ORTHOPEDIC SURGERY

Patient's Name: _____ **Patient's Date of Birth:**_____

Patient's Height: _____ **Patient's Weight**: _____

PRIMARY CARE PHYSICIAN: _____

PREFERRED PHARMACY w/address: _____

ALLERGIES: _____

_____

CURRENT MEDICATIONS: _____

_____

_____

_____

PAST MEDICAL HISTORY: Do you have or ever had any of these diseases or conditions? If yes, please circle

Anemia * Bleeding Disorder * Blood Clots * Peripheral Vascular Disease * Stroke * Blood Thinners * Heart Attack
Heart Disease * Arrhythmia * Pacemaker * High Blood Pressure * High Cholesterol * Other Heart Problems * Diabetes
Leg or Foot Ulcers * Thyroid Problems * Liver Disease * Hepatitis * Kidney Disease * Urinary Tract Infection *
Tuberculosis * GERD/Reflux * GI Disease * Ulcers * Hernia * Asthma * COPD * Pulmonary Embolism * Lung Disease
Neurologic Disease * Seizures/Epilepsy * Migraines * Fibromyalgia * Arthritis * Gout * Osteoporosis * Rheumatoid
Arthritis * Allergies * HIV or AIDS * Anxiety Disorder * Depression * Sleep Apnea * Obesity * Cancer
Other not listed: _____

_____

_____

PAST SURGICAL HISTORY: _____

_____

_____

_____

PATIENT'S IMMEDIATE FAMILY MEDICAL HISTORY: (Mother, Father, Brothers or Sisters) If yes, please circle

Heart Disease * High Blood Pressure * Kidney Disease * Diabetes * Cancer * Seizures * Rheumatoid Arthritis

Thyroid * Bleeding Disorder * Other:_____

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Patient's Name: _____ **Patient's Date of Birth:_____**

SOCIAL HISTORY:

What hand do you write with? ___Right ___Left ___Both

Marital Status: Married * Single * Divorced * Separated * Widowed * Domestic Partner

Chewing Tobacco: None * 1 a day * 2-4 a day * 5+ a day

Smoking Status: Never Smoker * Former Smoker * Current Every Day Smoker * Current Some Day Smoker

Smoking amount: 1 PPW * 2 PPW * ¼ PPD * ½ PPD * 1 PPD * 1½ PPD * 2 PPD * 3+ PPD

Has smoked since age: _____ If former smoker, number of years of tobacco use before quitting:_____

Alcohol Intake: None * Occasional * Moderate * Heavy How much used? _____

Do you use illicit drugs: Y * N Type of drug(s) and frequency?_____

Are you currently Employed? Y or N If yes, Employer: _____

Occupation: _____

Highest Education Level:_____ If current student, year in school: _____

Mobility Aids Used: Cane * Crutches * Walker * Wheelchair

Able to care for Self: Y * N

Do you live alone or with others? alone * with others If with others who?_____

What is your weight bearing status? None * toe touch only * 25% * 50% * 75% * 100% (full weight bearing)

Where do you currently reside? your home * someone else's home * Nursing Home * Rehabilitation/Skilled Nursing Facility. If a facility name of facility: _____

Is the complaint we are seeing you for today work related? Y * N

CURRENT INJURY or COMPLAINT:

Date of injury or onset of complaint: _____ Body part injured: _____

If injury, how it happened: _____

Did this injury occur while you were at work? _____

Is this an automobile related injury? _____

Have you been treated for this? _____ If yes, what facility & date(s): _____

What was done for this injury/complaint: _____

Were X-Rays taken? _____ If yes, what facility & date: _____

Were other studies performed? _____ If yes, what facility & date:_____