OrthopedicSurgeryBaldwin
NavicentHealthPhysicianGroup

Patient Name _____ Date: _____

Chief Complaint (Check one and indicate Right or Left side of body)

Hand _____ Foot _____ Wrist _____ Back _____ Arm _____ Knee _____

Ankle _____ Leg _____ Shoulder _____ Hip _____ Other _____

Date of First Occurrence: _____

*** Female Patients**: For purposes of taking x-rays, are you pregnant or trying? **Y / N**

Review of Systems: Do you experience or have you experienced any of the following (check all that apply)

Weight Loss	☐	Chest Pain	☐	Thyroid Trouble	☐
Weight Gain	☐	Hemorrhoids	☐	Anemia	☐
Head Injury	☐	Psychiatric Disorde	☐	Bleeding Easily	☐
Headaches	☐	Rashes	☐	Bruising Easily	☐
Asthma	☐	Numbness	☐	Wheezing	☐
Shortness of Breath	☐	Tingling	☐	Other:	☐

Allergies: (Drugs and others)

Allergen	Reaction

Allergen	Reaction

Current Medications:

Name	mg	Amount/Frequency	Prescribing Physician

Are you taking any diet medications? **Y / N**

Do you take any blood thinners? **Y / N**

Preferred Pharmacy: _____ Address: _____ City: _____

Medical History: Have you or members of your immediate family been told that you have:

	You	Family Member
Anemia		
Arthritis		
Asthma		
Prostate Problems		
Breast Cancer		
Coronary Artery Disease		
Cancer		
Congestive Heart Failure		
High Cholesterol		
COPD		
Dermatitis		
Diabetes		
Epilepsy		

	You	Family Member
Reflux Disease		
Gout		
Headaches		
Hepatitis		
HIV		
Hypertension		
Heart Attack		
Pneumonia		
Kidney Stones		
Stroke		
Tuberculosis		
Thyroid Disease		
Ulcer Disease		

Social History:

	Usage (circle one)	Amount
Cigarettes	Daily Weekly Monthly Prior Never	
Cigars	Daily Weekly Monthly Prior Never	
Pipe	Daily Weekly Monthly Prior Never	
Chewing Tobacco	Daily Weekly Monthly Prior Never	
Dipping Tobacco	Daily Weekly Monthly Prior Never	
Beer	Daily Weekly Monthly Prior Never	
Hard Liquor	Daily Weekly Monthly Prior Never	

Primary Care Physician: _____ Referring Physician: _____

Surgeries:

Description	Year	Hospital

By signing below I attest that the above information is true and correct to the best of my knowledge

Patient/Guardian Signature: _____ Date: _____