ORTHOPEDIC ASSOCIATES
65 Pennsylvania Avenue
Binghamton, NY 13903

PLEASE RESPOND TO EACH SECTION BELOW

Patient Name: _____ **D.O.B.** _____

Reason for this Visit? (Please describe your problem or injury) _____

_____

Date of injury or when problem began? _____ Were you injured at work? Y / N

Dates out of work due to problem? ____/____/_____ to ____/____/_____

Have you had x-rays/diagnostic studies taken for this problem? Y / N Did you bring them with you? Y / N

Where/when were they taken? _____ Have you had a Bone Density test? Y / N

Past Medical History (Please check all that apply) ☐ None apply

☐ Heart Disease / Murmur	☐ Lung disease	☐ Liver disease	☐ Diabetes	☐ Stroke
☐ High Blood Pressure	☐ Blood disorder/anemia	☐ Kidney disease	☐ Ulcers/Colitis	☐ Arthritis
☐ Congestive Heart Failure	☐ Blood clots / Phlebitis	☐ Skin disorders	☐ Osteoporosis	☐ Cancer

Other: _____

ALLERGIES: ☐ None ☐ Yes, please list _____

MEDICATIONS ☐ None ☐ Yes, please list

	dosage	times / day

PREVIOUS SURGERIES ☐ None ☐ Yes, please list

	year

Social History

Do you smoke? Y / N How many years? _____ How much / day? _____

Do you use alcohol? Y / N How much? _____ How often? _____

What is your dominant hand? Right _____ Left _____ Ambidextrous _____

Please describe your current job and its duties. _____

Review of Systems **(Do you have problems with any of the following? Please check all that apply.)** ☐ None apply

☐ Headaches	☐ Urinary problems	☐ Swelling in feet or ankles
☐ Vision changes	☐ Constipation / Diarrhea	☐ Fever / Chills
☐ Cough / Sore throat	☐ Chest pain / pressure	☐ Numbness in hands / feet
☐ Shortness of Breath	☐ Unintentional weight loss / gain	☐ Varicose Veins

Family History ☐ None apply or list:

		family member			family member
High Blood Pressure	Y / N	_____	Diabetes	Y / N	_____
Heart Disease	Y / N	_____	Cancer	Y / N	_____
Anesthesia Reaction	Y / N	_____	Arthritis	Y / N	_____
Mental Illness	Y / N	_____	Stroke	Y / N	_____

I attest that this information provided is true and correct to the best of my knowledge.

_____ _____

Patient Name **(please print)** Date **Signature** of Patient / Parent / Guardian

Relationship to Patient _____ Date _____