PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT: _____

ORTHOPEDIC ASSOCIATES

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□ Kamlesh Desai, M.D.	**□ Laurence Schenk, M.D.**	**□ Eric Seybold, M.D.**	**□ Heather Hazlett, RPA-C**
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□ Michael McClure, M.D.	**□ David Ellison, M.D.**		**□ Jonathan Gdovin, RPA-C**

Patient Name: _____Date of Birth: _____ Date: _____

PERSONAL MEDICAL HISTORY (Please check all that apply & explain below.)

□ Diabetes	□ Asthma	□ Hepatitis
□ High Blood Pressure	□ Emphysema / COPD	□ Liver disease
□ Heart Attack	□ Stroke	□ Kidney disease
□ Coronary Artery Disease	□ Seizure disorder	□ Thyroid disease
□ Irregular Heart Beat or Murmur	□ Depression	□ Skin disorders
□ Congestive Heart Failure	□ Nervous tendencies	□ Osteoarthritis
□ High cholesterol / triglycerides	□ Parkinson's disease	□ Rheumatoid Arthritis
□ Bleeding disorder	□ Heartburn / Reflux	□ Anesthesia reactions
□ Blood clots / Phlebitis	□ Ulcers / Colitis	□ Osteoporosis
□ History of blood transfusions	□ Enlarged Prostate	□ Cancer _____
□ Anemia	□ Gynecologic problems	_____

_____

_____

_____

PAST SURGICAL HISTORY (Please list all previous surgery and dates performed.)

_____

_____

_____

_____

_____

MEDICATIONS (Name, strength, dosage & reason.)

_____

_____

_____

_____

_____

_____

ALLERGIES (Please list medication and reaction.) Latex allergy? Y or N Reaction: _____

_____

_____

SOCIAL HISTORY

Age: _____ Occupation? _____ Do you live alone? Y or N

Tobacco Use (amount & how long?) _____ Do you wear glasses or contacts? Y or N

Alcohol Use (amount & how often?) _____ Do you wear dentures or partials? Y or N

(Continued on Back)

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

FAMILY MEDICAL HISTORY (Please mark all that apply by listing appropriate family member(s).)

High Blood Pressure: _____ Mental Illness: _____

Heart Disease: _____ Cancer: _____

Diabetes: _____ Arthritis: _____

Stroke: _____ Anesthesia Reaction: _____

REVIEW OF SYSTEMS (Have you had any recent changes/problems with the following? If yes, explain.)

Headaches_____ Bowel / Bladder _____

Vision changes _____ Swelling in feet or ankles _____

Hearing / Nose / Throat _____ Constipation / Diarrhea_____

Cough / Shortness of Breath _____ Hormonal _____

Chest pain / Heart _____ Significant weight loss / gain _____

Fever / Chills _____ Neurological _____

FEMALE PATIENTS

When was your last menstruation cycle? _____ Is there a possibility you maybe pregnant? Y or N

When was your last Pap smear? _____ Last mammogram / breast exam?_____

I attest that the information on this form is true to the best of my knowledge.

Patient/Parent/Guardian Signature: _____ ***Date:*** _____

(For office use only) ****

HPI:_____

_____

_____

_____

PHYSICAL EXAMINATION Height: _____Weight: _____ BP: _____ Pulse: _____

General Assessment _____

HEENT_____

Neck_____

Heart _____

Lungs _____

Abdomen _____

Extremities _____

Spine _____

Skin _____

Neuro _____

Assessment: _____

Plan:_____

_____

I attest that the risk, benefits and alternatives to this procedure have been discussed with the patient and/or family.

Provider(s) Signature: _____ Date: _____