ADVANCED ORTHOPEDICS

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Knee & Shoulder Specialists

Board Certified Orthopedic Surgeons
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Patient Name______________________________ Date Of Birth_____/_____/_____ Age_____

Height__________ Weight__________ Right or Left Handed________________

General Questions

Reason for consultation?____

When did your symptoms first occur?____

Who is your primary care physician?____

Who referred you to this office?____

Have you seen any other doctors for this problem?____

Have you had any X-Rays, MRI, or testing done?____

If so, when and where were they done?____

List any surgeries you have had and when.____

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Have you had any reactions to anesthetic?____

Do you take aspirin or blood thinners?____

Is there a chance you could be pregnant?____

Do you smoke?_____ If so, how much?___________ Do you drink?_____ If so, how much?___________

Medications (Provide List If Available)

Medication	**Dosage**	**Frequency**

Do you have any allergies to medications?____

Social/Family History

Are your parents living?_____________ If not, cause of death?______________________________________

Are your siblings living?_____________ If not, cause of death?______________________________________

List any history of cancer in your family. Who?____________________What Type?__________________

Serious Medical Conditions in Relatives.____

See reverse side…