RADFORD ORTHOPEDIC CENTER, P.C.

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IMPORTANT! PLEASE FILL THIS FORM OUT ENTIRELY!

IF IT DOES NOT APPLY TO YOU, PLEASE PUT ANSWER N/A. THANK YOU FOR YOUR COOPERATION!

Patient:_____ _____ Date:_____

Family Doctor:_____Height:_____ Weight:_____

Past/Present Medical History – circle all that apply

Chest pain _____ Stroke_____ HIV_____
Heart attack_____ Arthritis_____ Cough w/sputum_____
Heart murmur_____ Seizures_____ Asthma_____
High blood pressure _____ Cancer_____ Emphysema_____
Pacemaker _____ Skin problems_____ Sleep apnea_____
Irregular Pulse _____ Difficulty swallowing_____ Pneumonia_____
Congestive heart failure _____ Heartburn_____ Shortness of breath_____
Coronary heart disease _____ Hiatal hernia_____ Tuberculosis_____
High cholesterol _____ Thyroid disease_____ Jaundice_____
Depression_____ Kidney problems_____ Diabetes_____
Anemia _____ Difficulty urinating_____ Blood clot disorder_____
_____

Surgeries – circle all that apply

Shoulder scope _____ ACL repair_____ Appendectomy _____
Tonsillectomy _____ Gallbladder _____ Hysterectomy_____
Cataracts_____ Hernia _____ Knee scope_____
List any other surgical procedures:_____
_____
_____
Complications with anesthesia: yes___no___ Explain: _____
Date of last period:_____

Circle all that apply

Hearing: normal__aids_____impaired
Vision: normal___glasses___contacts___glaucoma
Dentures: none___upper___lower___
Partial: upper____lower_____

Alcohol intake: no __yes____ amount/day_____
Smoke Cigarettes: no___yes___ amount/day_____
Chew tobacco: no___yes___ amount/day_____
Marijuana: no___yes__ _amount/day_____

Family History: Has any blood relative ever had: check all that apply

Alzheimer's_____ Cancer_____ High blood pressure____ Memory loss_____Tuberculosis__
Asthma_____ Diabetes_____ High cholesterol_____ Osteoporosis_____Other_____
Bleeding problems____ Heart disease___ Kidney disease_____ Stroke_____

Medications:_____ Allergies:_____