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ORTHOPAEDICCARE
SHOULDER · HAND · ELBOW

PATIENT INFORMATION FORM

Today's date_____

Last Name: _____First Name: _____ M.I. _____

Primary Care Physician_____

Who referred you to us?_____

Social Security #_____Date of Birth_____ Age_____

Home Address: Street: _____ City _____State _____ Zip _____

Phone (Home): _____ (Work): _____

Employer: _____

Employer Address: _____City _____ State _____ Zip _____

Emergency Contact Person: _____Relationship: _____

Emergency Contact Phone (Home): _____(Work): _____

Check if Relevant:

☐ **Latex allergy** ☐ **Take Coumadin…** ☐ **Take another type of blood thinner**

Your Visit Today is covered by:

☐ **Worker's Compensation Claim/Carrier**

Employer_____Claim Number_____Insurance Carrier_____

☐ **Motor Vehicle Accident/Carrier**

☐ **Liability case/personal Injury**

☐ **Personal Insurance**

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What hurts? ☐**Shoulder** ☐**Hand** ☐**Elbow**

Side? ☐**Right** ☐**Left** ☐**Both**

Date symptoms began or injury occurred: _____

Tell us <u>how</u> your injury occurred and <u>what treatment</u> you've had.

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Allergies:

Please list your medicines or bring in a list for us to copy			
Do you smoke?	☐ **Yes**	☐ **No**	**Packs per day** _____
Do you drink alcohol?	☐ **Yes**	☐ **No**	**Drinks per day** _____

Medical History:

	Yes	**No**	**When**	**Describe**
Heart Disease				
Stroke				
Diabetes				
High Blood Pressure				
Vascular/circulation problem				
Blood clot – leg or lung (DVT/PE)				
Arthritis (type)				
Stomach/intestine problem				
Cancer (type)				
Bleeding problem				
Clotting problem				
Nerve related problem (type)				
Breathing problem, asthma				
Kidney problem				
Thyroid problem				
Hepatitis or liver disease				
Depression/Psychiatric problem				
Severe sprains or dislocations				
Broken bones				
Previous Surgery				

List previous Surgical procedures:

Review of systems: (check all that apply)

Gastrointestinal	☐ ulcer ☐ hiatal hernia ☐ frequent indigestion ☐ colitis ☐ blood in stool
Urinary	☐ kidney stones **Urination is:** (circle all that apply) ☐ difficult ☐ frequent ☐ painful ☐ burning ☐ bloody
Neurological	☐ paralysis ☐ weakness ☐ numbness ☐ tingling in arms or legs ☐ seizures ☐ tremor
Skin	☐ chronic rashes ☐ itching ☐ sores that don't heal ☐ infections or boils
Vascular, Hematological and Lymphatic	☐ vein problems ☐ phlebitis ☐ clots ☐ anemia ☐ bleeding problems ☐ calf pain when walking ☐ easy bruising ☐ swollen node
Cardiac and Pulmonary	☐ chest pain ☐ shortness of breath ☐ chronic cough ☐ irregular heart beat ☐ heart murmur ☐ wheezing
Endocrine	☐ weight loss or gain ☐ excessive sweating
Musculoskeletal	☐ swelling in multiple joints ☐ excessive flexibility of joints ☐ fibromyalgia

Patient signature: _____ **Date:** _____