



TOWN CENTER
 ORTHOPAEDIC ASSOCIATES, P.C.
Specialized Physicians. Specialized Care.

Patient Information Form

Name: _____ Today's Date: _____
 Height: _____ Weight: _____ Sex: M F Date of Birth: _____
 Self Referral: ____ or Referring Doctor: _____ Age: _____ R L Handed
 Why are you seeing the doctor today? _____

Have you ever had a similar problem before? No Yes If yes, explain: _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

How long has this been bothering you? _____

If this was an injury, describe when and how the injury occurred: _____

What treatment have you had for this problem? _____

Medication	Dose	Reason for Medication

Allergies: _____

Past Medical History

Surgeries/Hospitalization	Year

Have you every had problems with anesthesia? No Yes

If yes, describe: _____

(PLEASE COMPLETE OTHER SIDE)



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Review of Systems

Have you ever had problems with your:

	Circle	Describe all yes responses
Eyes	Yes No	_____
Ears, nose, throat	Yes No	_____
Digestive problems	Yes No	_____
Bladder or prostate problem	Yes No	_____
Diabetes	Yes No	_____
High blood pressure	Yes No	_____
Heart disease	Yes No	_____
High cholesterol	Yes No	_____
Kidney disease	Yes No	_____
Bleeding problems	Yes No	_____
Hepatitis or liver disease	Yes No	_____
Depression	Yes No	_____
Cancer	Yes No	_____
Arthritis	Yes No	_____
Lungs or breathing problems	Yes No	_____
Seizures or neurologic disease	Yes No	_____

Family History

Significant family history: _____

Social History

Employed (occupation: _____) Student Retired

Single Married Divorced Widowed

Children? No Yes# _____

Exercise? Daily Weekly Rarely

What type of exercise? _____

History of substance abuse? No Yes What type? _____

Smoke currently? No Yes If yes, _____ packs per day for _____ year

Quit smoking? No This year > 5 years > 10 years

Alcohol consumption? Never Daily 1-2 times per week Rarely

Patient or Responsible Party Signature

: _____ Date: _____

Reviewed By: _____ M.D. Date: _____