

Name: _____

Chart: **Peachtree Orthopaedic Clinic**

Date: _____

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ PHARMACY PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRAL SOURCE: _____

REASON FOR TODAY'S VISIT: _____

IS THIS DUE TO AN INJURY? YES _____ NO _____ IF YES, DATE OF INJURY: _____

WORKERS COMPENSATION CLAIM: YES _____ NO _____

MOTOR VEHICLE ACCIDENT: YES _____ NO _____ LITIGATION PENDING: YES _____ NO _____

MARK ALL CURRENT AS WELL AS PREVIOUS ILLNESSES:

HEIGHT: _____ WEIGHT: _____ CARDIAC PROBLEMS: YES _____ NO _____

ASTHMA: YES _____ NO _____ DEFIBRILLATOR YES _____ NO _____

HIGH BLOOD PRESSURE: YES _____ NO _____ PACEMAKER: YES _____ NO _____

STROKE(S): YES _____ NO _____ CARDIAC STENTS YES _____ NO _____

SEIZURE/CONVULSIONS: YES _____ NO _____ OTHER: _____

BLEEDING TENDENCY: YES _____ NO _____ DIABETIC: YES _____ NO _____

THYROID DISORDER: YES _____ NO _____ TYPE I _____ TYPE II _____

MENTAL ILLNESS: YES _____ NO _____ HISTORY OF ULCERS: YES _____ NO _____

SLEEP APNEA? YES _____ NO _____ HISTORY OF CANCER: YES _____ NO _____

ARE YOU PREGNANT? YES _____ NO _____ RHEUMATOLOGIC DISEASE: YES _____ NO _____

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS THAT AFFECT YOUR BONES OR JOINTS? _____

PLEASE LIST ALL SURGERIES:

_____ DATE: _____ _____ DATE: _____

_____ DATE: _____ _____ DATE: _____

_____ DATE: _____ _____ DATE: _____

_____ DATE: _____ _____ DATE: _____

PLEASE LIST ALL SERIOUS ILLNESSES/ACCIDENTS:

_____ DATE: _____ _____ DATE: _____

_____ DATE: _____ _____ DATE: _____

PLEASE LIST ALL CURRENT MEDICATIONS:

NAME	DOSE	CONDITION	NAME	DOSE	CONDITION
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATIONS REVIEWED AND CONFIRMED AS ACCURATE:

Physician Signature Date

DO you have any DRUG ALLERGIES? YES _____ NO _____

If yes, please list: _____

Do you have a LATEX ALLERGY? YES _____ NO _____

Information verified with patient today with the following changes noted:

Physician Signature: _____ Date: _____

