

# ORTHOPEDIC ASSOCIATES OF LAKE CO. MEDICAL INFORMATION

Patient Name: _____	Family Physician & phone #: _____
Date: _____	Would you like a copy of your office note sent to your family physician? <input type="checkbox"/> Yes <input type="checkbox"/> No

## CURRENT INJURY OR COMPLAINT

Date of injury or onset symptoms: _____	Referred by: _____
Description of injury or symptoms: (Please give details) _____ _____	
Previous treatment for this problem: <input type="checkbox"/> ER <input type="checkbox"/> Urgent Care <input type="checkbox"/> X-rays <input type="checkbox"/> MRI <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Family Physician <input type="checkbox"/> Other (please give details)	
Are you currently off work for this problem: <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please give last date worked: _____	

## PATIENT HEALTH HISTORY

Allergies: _____	Height: _____	Weight: _____
<b>Current Medications with Strength and Frequency, please include any over-the-counter medications or supplements</b>		
1) _____	5) _____	
2) _____	6) _____	
3) _____	7) _____	
4) _____	8) _____	
Do you use tobacco?	If yes, amount:	# of years
Do you use alcohol?	If yes, amount:	#of years
Do you use any other drug or substance? If yes, list name, amount, and # of years used		

MEDICAL PROBLEMS	PAST SURGICAL PROCEDURES	SOCIAL HISTORY
___ Heart ___ Ulcers ___ Asthma ___ Diabetes ___ Hepatitis ___ Blood Pressure ___ Blood Disorders ___ Other _____	Date & Procedure _____ _____ _____ _____	Please list your favorite hobbies/activities _____ _____ _____ _____

NATURE OF WORK/JOB DESCRIPTION \_\_\_\_\_ (sitting, standing, walking)

FAMILY HEALTH HISTORY Please list any significant diseases or cause of death

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brother or Sister \_\_\_\_\_

Spouse \_\_\_\_\_

Other \_\_\_\_\_