

New Hope Orthopaedics & Sports Medicine
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Welcome to our Practice. Please fill out the information below to the best of your ability.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

CHIEF COMPLAINT: _____

INJURY/ONSET OF SYMPTOMS (For insurance purposes it is often required to list an exact date of injury or onset of symptoms. If you are not sure, please give approximate date.)

Date of Injury / Onset of Symptoms: Month: _____ Day: _____ Year: _____

What part of the body is to be treated? _____ Right _____ Left _____

How did injury occur? _____

Have you retained an attorney to assist you with your claim Y or N? If yes, Name of Attorney _____

If female: Are you pregnant? YES NO Are you Nursing? YES NO

Have you been treated with steroids or cortisone within the past 2 months? YES NO

MEDICAL HISTORY: (Please check all that apply)

- | | | |
|----------------------------------------------|---------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CORONARY ARTERY DISEASE | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> ANXIETY-DEPRESSION | <input type="checkbox"/> CONCUSSION (HEAD INJURY) | <input type="checkbox"/> HIV INFECTION |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> KIDNEY DISEASES |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> EPILEPSY (SEIZURES) | <input type="checkbox"/> LIVER DISEASES |
| <input type="checkbox"/> BLEEDING TENDENCIES | <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> PEPTIC ULCER DISEASE (ULCERS) |
| <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEART ATTACK (MI) | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> HEART DISEASE | OTHER _____ |

Have you or your family had any problems with anesthesia for surgery? YES NO

Family History _____

SOCIAL HISTORY:

Use of tobacco: Never Previously, but quit _____ Currently packs per day _____

Use of alcohol: Never Previously, but quit _____ Currently drink: Rarely Moderately Daily

Type of alcohol: _____

SURGERIES (OPERATIONS): (Please list dates and Surgeon's names)

SURGERY	DATE	SURGEON
1. _____		
2. _____		
3. _____		

MEDICATIONS (Please list prescription and nonprescription drugs, including Natural or Herbal Supplements)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you have a Latex Allergy? YES NO

MEDICATION ALLERGIES: (Please give name of drug and what happened when you took it, e.g. rash, itching, etc.)

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |