TDC ORTHOPEDIC AND SPORTS MEDICINE CENTER

BASIC INFORMATION SHEET

Name: Today's Date:
Age: Date of Birth:
Medical Insurance: OR Private Pay
Worker's Comp. (State L&I, Self Insured, OWCP-Federal) Claim#: _____
How were you referred here? (Self, Friend, Doctor) _____ Primary MD: _____
List other physicians that you see_____

Past Medical History: Have you ever had the following:

- ☐ Y Acid Reflux/ GERD
- ☐ Y Asthma
- ☐ Y Chicken Pox
- ☐ Y Cancer
- ☐ Y COPD
- ☐ Y Diabetes
- ☐ Y DVT (Deep Venous Thrombosis)
- ☐ Y Hepatitis
- ☐ Y HIV Infection
- ☐ Y Hypertension
- ☐ Y MI (Myocardial Infarction)
- ☐ Y Atrial Fibrillation
- ☐ Y CHF (Congestive Heart Failure)
- ☐ Y Heart murmur
- ☐ Y Pace Maker
- ☐ Y Pulmonary Embolism
- ☐ Y Stroke
- ☐ Y Reaction to anesthetics
- ☐ Y Other past medical history.

Past Surgical History: PLEASE INCLUDE DATES

- ☐ Y Ankle Surgery
- ☐ Y Back Surgery
- ☐ Y Elbow Surgery
- ☐ Y Foot Surgery
- ☐ Y Appendectomy
- ☐ Y CABG (CABG)
- ☐ Y Cataract Surgery
- ☐ Y Cesarean Section
- ☐ Y Gastric Surgery
- ☐ Y Hand Surgery
- ☐ Y Hip Surgery
- ☐ Y Hip replacement
- ☐ Y Knee Surgery
- ☐ Y Cholecystectomy
- ☐ Y Hemorrhoidectomy
- ☐ Y Hernia Repair
- ☐ Y Hysterectomy
- ☐ Y Prostate Surgery
- ☐ Y Knee replacement
- ☐ Y Neck Surgery
- ☐ Y Rotator Cuff Repair
- ☐ Y Shoulder Surgery
- ☐ Y Tonsillectomy/Adenoidectomy
- ☐ Y Thyroid Surgery
- ☐ Y Other past surgical history

Drug Allergies: _____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

Latex Allergy? Yes If yes, what type _____

Current Medications: Type Dose How Often For What Condition?

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Please continue on the back if need be.

Social History:

- ☐ Y Left-Handed
- ☐ Y Right-Handed
- ☐ Y No Hand Preference

Occupation: _____

Marital history: Married Single Widowed Divorced Partnered

- ☐ Y ☐ N Alcohol Use: Type and Frequency
- ☐ Y ☐ N Drug Use: Type and Frequency
- ☐ Y ☐ N Tobacco use: Type and Frequency

Current Smoker ***Former Smoker*** ***Never a Smoker*** ***Chewing nicotine-containing substances***

Family History: List relationship-Living or Deceased

- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N HTN
- ☐ Y ☐ N Osteoarthritis
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Reaction to anesthetics
- ☐ Y ☐ N List any other pertinent information

Continued on page 2

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First Name Last Name»

Review of Systems

Systemic
- Y N feeling fine
- Y N feeling tired (fatigue)
- Y N fever [as symptom]
- Y N chills [as a symptom]
- Y N Night sweats
- Y N recent change in weight

Eyes
- Y N vision problems

Otolaryngeal
- Y N loss of hearing
- Y N ringing in the ears

Skin
- Y N skin lesions [Sx]
- Y N itching (pruritus)

Cardiovascular
- Y N chest pain or discomfort
- Y N Palpitations

Pulmonary
- Y N difficulty breathing
- Y N cough
- Y N wheezing

Gastrointestinal
- Y N nausea
- Y N heartburn
- Y N vomiting

Genitourinary
- Y N pain during urination
- Y N urinary frequency

Endocrine
- Y N excessive thirst / fluid intake
- Y N temperature intolerance to cold

Hematologic
- Y N easy bleeding
- Y N easy bruising tendency

Musculoskeletal
- Y N back pain
- Y N muscle aches
- Y N joint pain, localized
- Y N joint swelling, localized
- Y N joint stiffness, localized

Neck
- Y N neck pain
- Y N neck stiffness

Head
- Y N chronic / recurring headaches
- Y N MIGRAINE HEADACHE

Neurological
- Y N dizziness
- Y N muscle weakness
- Y N memory lapses or loss
- Y N sensory disturbances

Psychological
- Y N insomnia
- Y N anxiety
- Y N depression

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____

Signature of Patient / Parent / Guardian **Date**

Doctor's Review

_____

Signature of Doctor **Date**