

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:

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

Past Surgical History: PLEASE INCLUDE DATES

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

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: _____

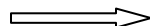
Marital history: Married Single Widowed
Divorced Partnered

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

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

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



Continued on page 2

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