Lancaster Orthopaedics & Sports Medicine

Patient Name: _____ DOB: _____ Age: _____ Sex: M / F

Dominant Hand ___ R ___ L Height _____/_____ Weight _____ Problem Site: _____

When did it begin (date)? _____ **Is this work-related? Y N** Is this due to an auto accident? __Y __ N

Have you ever had a problem like this before? __ Y __ N Are you a student? __ Y __ N Are you disabled? __ Y __ N Reason: _____

What is the main reason for today's visit? __Pain __Numbness __Weakness __Swelling __Stiffness ___Other

Who referred you to our office?_____ Who is your primary care physician? _____

PAST MEDICAL / SURGICAL HISTORY Do you presently have or have you ever been diagnosed with any of these illnesses?

☐ High Blood Pressure ☐ Diabetes ☐ Stomach Ulcers ☐ Cancer ☐ Depression ☐ Stroke
☐ Heart Disease ☐ Arthritis ☐ Asthma ☐Blood Clots in legs ☐Kidney Disease
☐Liver disease ☐Problems with/Reaction to Anesthesia for surgery List Others:_____ ☐**NONE**

SURGERIES/HOSPITALIZATIONS: List each type of surgery or reason for hospitalization and indicate the approximate year:

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY: Please answer ALL questions

Do you have children? **Y/N** If yes, how many? ____ Pregnant/ nursing? **Y /N** Marital Status: _____
Education/Grade: _____ Job/Occupation: _____ Employer: _____ Do you wear a seatbelt? **Y /N**
Do you drink caffeine? __ None __ Moderate __ Heavy Have you ever had possible exposure to the AIDS virus? **Y/N**
Do you smoke? **Y/N** ___ Cigarettes ___ Pipe/ # Years ___ If yes, how much do you smoke? ___ (packs/day)
Do you drink alcohol? **Y /N** If yes, how many ounces / beers / drinks per day / week? _____
Have you ever used drugs or substances not prescribed by a healthcare provider? **Y/N** If Yes, which drugs/substances? _____
Do you live with others? Y/N

MEDICATIONS: Please list any medications you are currently taking, including over the counter, vitamins and herbal medications. Please bring these medications with you to each appointment. ☐**See attached list**

Medication	Dosage	How often		Medication	Dosage	How often

ALLERGIES: ☐Penicillin ☐Aspirin ☐Sulfa ☐Codeine ☐Novocain ☐Iodine ☐Latex ☐No Known Allergies

List Other Allergies: **PREFERRED PHARMACY:**

REVIEW OF SYSTEMS: Do you presently have any of the following conditions? YES or NO must be circled.

Y/N Headaches	Y/N Chest Pain	Y/N Numbness	Y/N Seizures	Y/N Problems Sleeping
Y/N Constipation	Y/N Watery Eyes	Y/N Indigestion	Y/N Weakness	Y/N Skin Ulcers
Y/N Joint Swelling	Y/N Fainting Spells	Y/N Blurry Vision	Y/N Joint Pain	Y/N Anxiety
Y/N Rashes	Y/N Cough	Y/N Weight Loss	Y/N Diarrhea	Y/N Wheezing
Y/N Incontinence	Y/N Leg Swelling	Y/N Shortness of Breath	Y/N Burning with urination	

FAMILY HISTORY: Check if any blood relatives have had any of the following and indicate relationship in the blank provided:
If there are no known conditions, please check this box. **MATERNAL OR PATERNAL** ☐**NONE**

☐ Stroke _____ ☐ Diabetes _____ ☐ Cancer _____
☐ Heart Attack _____ ☐ Kidney Disease _____ ☐ Leukemia _____
☐ Bleeding Tendency_____ ☐ Arthritis _____ ☐ High Blood Pressure_____
☐ Epilepsy _____ ☐ Emphysema_____ ☐ Tuberculosis_____
☐ Blood Clots _____ ☐ Sudden Death_____ ☐ Colitis_____
☐ Rheumatic Heart Disease _____ ☐ Congenital Heart Disease_____
☐ Heart Failure_____ ☐ Problems with/Reaction to Anesthesia for surgery _____

Please sign below stating the above information is accurate to the best of your knowledge.

Patient Signature: _____ **Date:** _____