Ellis & Badenhausen Orthopaedics, PSC

Patient Name _____Date of Birth_____

Today's Date _____ Occupation _____

Height _____ Weight _____ Are you Pregnant? _____ Date of Injury _____

Family Doctor _____

Local Pharmacy/Phone Number/ Address _____

How were you referred to us? _____

Reason for visit? _____

_____

_____

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

Are You Allergic to Metal? _____ Which Type of Metal?_____

Medications	Dosage	Times per day	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Problems: e.g. Diabetes, Cancer, High Blood Pressure, Heart Disease,

_____

_____

Previous Surgeries	When
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Smoking: Yes No Pack per day _____ Alcohol/Drugs: Yes No Amount _____

Family History: (Please Circle or add your family's specific problem)
Arthritis, Bone Problems, Cancer, Diabetes, Heart, Kidney, or Bleeding Problems, Stroke

_____

_____

Please continue on the back!

Do **YOU** have: (Please circle or add your specific problem)
Weight Loss, Fever, Unusual Fatigue _____
Visual Problems _____
Heart Problems, Chest Pain (Irregular Beats) _____
Shortness of Breath, Wheezing, Chronic Cough _____
Stomach Pain, Vomiting Blood, Frequent Diarrhea, Ulcers _____
_____
Prostate Problems, Kidney Disease or Stones, Bladder Infections _____
_____
Arthritis, Other Bone, or Joint Problems _____
Rashes (Psoriasis), Jaundice, Large Birthmarks, Other Skin Problems _____
_____
Numbness, Tingling, Seizures, Fainting, Weakness _____
Depression, Hallucinations, Other Psych Problems _____
Diabetes, Thyroid Problems, Gland Disorders _____
Free Bleeding, Anemia, Enlarged Lymph Nodes _____
Allergies to Food, Rubber, or Metals _____
HIV, Hepatitis, Tuberculosis _____
Other: _____

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Additional Comments: _____

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Blood Pressure_____ Pulse _____