

Past Medical History

Please indicate if you have ever experienced any of the following conditions.

- | | | |
|---------------------------------------------------|------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Blood Clots / DVT | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke (CVA) (TIA) |
| <input type="checkbox"/> Cancer
Type: _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Irritable Bowel (IBS) | <input type="checkbox"/> Other: _____
_____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoarthritis | |
| <input type="checkbox"/> Esophageal Reflux | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis | |
| | <input type="checkbox"/> Seizures / Epilepsy | |

Surgical History

Surgery	Physician	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Please check if any family member has had any of the following conditions: OR: **Adopted**

<u>Family Member</u>	<u>COMMENTS</u>
<input type="checkbox"/> Blood Clots (DVT)	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Cancer Type: _____	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Osteoarthritis	_____
<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Peripheral Vascular Disease	_____
<input type="checkbox"/> Seizures/Epilepsy	_____
<input type="checkbox"/> Stroke (CVA)	_____
<input type="checkbox"/> Other: _____	_____

Social History

Do you use tobacco Yes No Former Type of tobacco used _____/_____
Packs per day _____ Years smoked _____ Year Quit _____
Other Tobacco units per day (cans, cigars, etc) _____
Units per day _____ Years used _____ Year Quit _____

Do you drink caffeine Yes No Type _____ Amount Daily _____

Do you drink alcohol Yes No Former Year Quit _____
Type _____ How much per week _____
Amount _____ Last Drink _____

Hand Dominance: right left ambidextrous

Why are you seeing the doctor today? Right / Left Knee, Shoulder, Hip, Other _____

Date of Injury/accident if known: _____

Reason for visit:

I understand and agree that if I have no insurance coverage or if my claim is a result of a third party injury, payment is due at the time of service.

I understand and agree that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Advanced Orthopaedic Specialists.

I authorize Advanced Orthopaedic Specialists to release pertinent medical information to my insurance company when requested, to facilitate payment of a claim.

I understand and agree that it is my responsibility to inform the staff of Advanced Orthopaedic Specialists as to which hospital or outside facility is in my insurance network.

I give permission for Advanced Orthopaedic Specialists to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Signature of Patient or Responsible Party: _____ **Date:** _____
