UAB MEDICINE
ORTHOPAEDICS

Knowledge that will change your world

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Date of Service: _____

Physician: _____

PLEASE PRINT

NAME: _____ EMAIL ADDRESS: _____

REFERRING PHYSICIAN: _____ FAMILY/PRIMARY PHYSICIAN: _____

PHARMACY: _____LOCATION: _____ PHARMACY PHONE:_____

PRESENT WEIGHT _____ PRESENT HEIGHT_____ ETHNICITY_____ PREFERED LANGUAGE_____

CHIEF COMPLAINT:_____PAIN SCALE 1 2 3 4 5 6 7 8 9 10

Date of accident/injury/start of pain _____

If this was an accident, how did it occur? _____

What makes your condition worse? _____

What makes your condition better? _____

Have you been treated for this condition? If so, please describe _____

_____

OTHER ILLNESS YOU HAVE IF ANY:

_____

_____

_____

_____

PLEASE LIST ALL MEDICATIONS YOUR ARE NOW TAKING:

_____

_____

_____

_____

PAST HISTORY/REVIEW OF SYSTEMS (circle YES or NO) If "Yes is not circled, response will be considered negative.

HAVE YOU EVER HAD?						**Are you allergic to?**	
Free Bleeding	YES NO	HIV	YES NO	Stomach Ulcer	YES NO	Penicillin	YES NO
Heart Trouble	YES NO	Fainting Spells	YES NO	Kidney Trouble	YES NO	Sulfa	YES NO
Chest Pain	YES NO	Anemia (Low Blood)	YES NO	Varicose Veins	YES NO	"Mycin"	YES NO
Irregular Heart Beat	YES NO	Numbness in Extremities	YES NO	Leg Swelling	YES NO	Which One?_____	
High Blood Pressure	YES NO	Asthma	YES NO	Poor Circulation	YES NO	Aspirin	YES NO
Stroke	YES NO	Emphysema	YES NO	Diabetes	YES NO	Codeine	YES NO
Paralysis	YES NO	Anesthesia Problems	YES NO	Steroid Medication	YES NO	Tetanus	YES NO
Fever with Surgery	YES NO	Spitting up Blood	YES NO	Blood Thinner Pills	YES NO	Demerol	YES NO
Seizures	YES NO	Thyroid Trouble	YES NO	Blood Clots in Legs	YES NO	Latex	YES NO
Ringing in Ears	YES NO	Back Ache (Severe)	YES NO	Blood Clots in Lungs	YES NO	Other Medicine	YES NO
Dizziness	YES NO	Addiction Problems	YES NO	Blood Transfusion	YES NO	Other List Below: _____	
Loss of Vision	YES NO	Hepatitis	YES NO	Cancer	YES NO	_____	
		Jaundice	YES NO				

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FAMILY MEDICAL HISTORY (circle YES or NO) If "Yes is not circled, response will be considered negative.

HAS ANY BLOOD RELATIVE EVER HAD:			Who				
Bone Disease	YES	NO	_____	Mental Illness	YES	NO	_____
Osteoporosis	YES	NO	_____	Arthritis	YES	NO	_____
Tuberculosis	YES	NO	_____	Congenital Deformities	YES	NO	_____
Stroke	YES	NO	_____				
Diabetes	YES	NO	_____	Kidney Trouble	YES	NO	_____
Heart Trouble	YES	NO	_____	Anesthesia Problems	YES	NO	_____
High Blood Pressure	YES	NO	_____				
Cancer	YES	NO	_____	Fever with Surgery	YES	NO	_____

SOCIAL HISTORY (circle YES or NO) If "Yes is not circled, response will be considered negative.

Please advise your physician of any cultural or spiritual issue that may affect your care.

DO YOU

Smoke or use other tobacco products YES NO

If yes, how many packs per day?_____

Drink alcoholic beverages YES NO

If yes, average drinks per day _____

Marital Status: Single Married Widowed Divorced

Number of Children (if any) _____

Place of Employment _____

Type of Work: Sedentary Heavy Labor

LIST ANY OPERATIONS YOU HAVE HAD:

OPERATION	DATE	SURGEON	HOSPITAL

ADDITIONAL NOTES/COMMENTS:_____

_____

_____

PATIENT SIGNATURE: _____ **DATE:**_____

I HAVE REVIEWED THE INFORMATION PROVIDED ABOVE.

PHYSICIAN SIGNATURE: _____ **DATE:**_____