Greenleaf
ORTHOPAEDIC ASSOCIATES

PATIENT MEDICAL INFORMATION

Date: _____

Patient Name (Please Print): _____ Date Of Birth: _____

Height: _____ Weight: _____ lbs. Blood Pressure: _____ Sex: ☐Male ☐Female

Occupation: _____ ☐Retired ☐Disabled ☐Student ☐ Unemployed

What Medication do you take? Please List all Prescriptions, Over-the-Counter Meds, Supplements, and Vitamins.

Medication	Dose and Frequency	Medication	Dose and Frequency
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Please List any Allergies:

Allergy:_____Reaction:_____ Allergy:_____Reaction:_____

Allergy:_____Reaction:_____ Allergy:_____Reaction:_____

Please check the box if you have either: ☐Latex Allergy ☐Adhesive Tape Allergy

PHARMACY OF CHOICE

Pharmacy Name Intersection City, State Phone

_____

Tobacco use: ☐No ☐ Yes **Cigarette Packs per day**: _____ **Pipe?** ☐Yes ☐ No **Cigars** ☐ Yes ☐No

Chewing Tobacco?☐ Yes ☐ No **Do you use E-Cigarettes?(Vape)** ☐ Yes ☐ No

***** Would you like information on Quitting?** ☐ Yes ☐No

Alcohol use: ☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily **History of alcoholism?** ☐ Yes ☐ No

History of drug use? ☐Yes ☐No

Past Medical History – Please check all that apply:

☐ Asthma ☐ Hypertension ☐ Arthritis: Rheumatoid **or** Osteoarthritis? ☐ Osteoporosis ☐ Recurrent Infections

☐ Ulcers ☐ Bleeding Disorder ☐ Stroke ☐ Thyroid Disease ☐ Cancer: Body System/Location: _____

☐ Diabetes: Type I **or** Type II? ☐ High Cholesterol ☐ Heart Disease ☐ Kidney Disease

☐**Hepatitis** ☐ **HIV** ☐ **MRSA** ☐ **Tuberculosis** **Other**_____

Family History

	Living	**Deceased**	**Diabetes**	**Hypertension**	**Heart Disease**	**Cancer**	**Stroke**	**Mental Illness**	**Other**
Father									
Mother									
Sister(s)									
Brother(s)									

Surgical History

Procedure Date	Procedure

History of Present Illness

Description of the problem(s) or chief complaint(s): **(Right or Left?)**_____

_____

_____

Was there any injury that occurred? ☐ No If YES, how did the injury occur?: _____

_____

Where did the injury occur? _____

Date of Injury /Approximate Onset of pain:_____

Have you seen another physician for this? ☐No ☐ Yes

If yes, what physician did you see?: _____

Pain Assessment:

Intensity: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Did they order any tests or procedures? ☐No ☐Yes

If yes, what was ordered and where were they done at? _____

_____

Did your Primary Care Physician refer you to us? **If Yes**, Who is your doctor?_____

If No, how were you referred to us?_____

REVIEW OF SYSTEMS:

Have you ever experienced or do you currently have any of the following signs or symptoms? Please check the appropriate boxes.

General/Constitutional	☐ None	☐ Fever		☐ Loss of Appetite		☐ Other:
Allery/Immunology	☐ None	☐ Metal Allergies	☐ Shell Fish Allergies	☐ Latex Allergy		☐ Other:
HEENT/Neck	☐ None	☐ Ringing in ears		☐ Sinus Problems		☐Other:
Endocrine	☐ None	☐ Hot Flashes		☐ Thyroid Disorder High or Low?		☐Other:
Respiratory	☐ None	☐ History of Emphysema		☐ Shortness of Breath		☐Other:
Cardiovascular	☐ None	☐ High Cholesterol	☐ Chest Pain	☐ Irregular Heart beat		☐ Other:
Gastrointestinal (GI)	☐ None	☐ Cirrhosis		☐ Acid Reflux		☐ Other:
Hematology	☐ None	☐ Sickle Cell Disease		☐ Anemia		☐ Other:
Genitourinary	☐ None	☐ Loss of Control of Urine	☐ Kidney Disease	☐Kidney Stones		☐ Other:
Dermatologic	☐ None	☐ Shingles		☐ Psoriasis		☐ Other:
Neurological	☐ None	☐ Dizziness		☐ Headache		☐ Other:
Psychiatric	☐ None	☐ Addiction Disease		☐ Depression		☐ Other:

Are you or could you possibly be pregnant? ☐Yes☐ No