BONE AND JOINT CARE CENTER
A Division of Keystone Orthopaedic Specialists, LLC

PATIENT INFORMATION: Today's Date: _____

Patient Name: _____ Date of Birth: _____

Referring Physician: _____ Family Physician: _____

Patient's Height: _____ Patient's Weight: _____

MEDICATIONS/ALLERGIES:
List your current Medications & doses:

_____

_____

_____

_____

_____

_____

List Allergies to medications or substances:

_____

_____

_____

MEDICAL HISTORY:
Check (☐) you have or have had in the past.

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
  Type: _____
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ DVT
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Disease
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Ulcers
- ☐ Other _____
  _____
  _____
  _____

REVIEW OF SYSTEMS:
Check (☐) you have or have had in the past.

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/BONE/JOINT
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GASTROINTESTINAL
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Excessive Thirst
- ☐ Rectal Bleeding
- ☐ Vomiting Blood

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Freq./Painful Urination

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High/Low Blood Pressure
- ☐ Irregular/Rapid Heartbeat
- ☐ Poor Circulation

EYE, EAR, NOSE, THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Difficulty Swallowing
- ☐ Earache/Ear discharge
- ☐ Vision:Halos/Flashes
- ☐ Cataracts
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Ringing in ears
- ☐ Persistent Cough
- ☐ Hearing Loss
- ☐ Glaucoma

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash Scars
- ☐ Changes in moles
- ☐ Sore that won't heal
- ☐ Lump in testicle/breast

WOMEN ONLY
Date of last:
Menstrual period _____
Mammogram _____
Pap smear _____

Please turn the page over and complete the back side of the form.

HOSPITALIZATION/SURGERY:

Year	Hospital	Reason for Hospitalization/Type of Surgery

Have you ever had a blood transfusion?

☐ No ☐ Yes

If yes, please give dates: _____

Have you ever had any complications from anesthesia?

☐ No ☐ Yes

FAMILY HISTORY: Any blood relatives with the following:

(✓)	Disease	Relationship to You
	Arthritis	
	Asthma	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Gout	
	Hay Fever	

(✓)	Disease	Relationship to You
	Heart Disease	
	High Blood Pressure	
	Kidney Disease	
	Strokes	
	Tuberculosis	
	Other: _____ _____	

HEALTH HABITS: Check (☐) substances you use and amount.

☐ Caffeine _____
☐ Tobacco _____
☐ Drugs _____
☐ Other _____

Living Arrangements:
☐ Live alone
☐ Live with someone
☐ Live in single level home
☐ Live in multi-level home

DEMOGRAPHIC INFORMATION:

Home Address: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____ Email Address: (optional) _____

Employer Name & Address: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any of his/her staff responsible for any errors or omissions that I may have made in completion of this form

Signature _____ Date _____