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
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ 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	
	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: _____ Social Security Number: _____
_____ Email Address: (optional)_____
Telephone Number: (Home) _____ (Work) _____ _____
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 _____