NJ Ortho Group, LLC

MEDICAL INFORMATION

Height _____ ft. _____ in. Weight _____ lbs. Blood Pressure:_____ Pulse:_____

MEDICATIONS

Do you take any of the following medicines on a regular basis?

☐ Aspirin ☐ Birth control pills ☐ Tylenol ☐ Coumadin/Plavix ☐ Anti-inflammatories

Please list any medications you are taking, with dose & frequency: _____

_____

_____

Do you have any allergies to medications? ☐ yes ☐ no If YES please list:_____

_____

MEDICAL HISTORY

If 18 yrs. or younger, have you received all of your pediatric immunizations/vaccinations? YES ◯ NO ◯

Female patients please give the date of your last menstrual cycle: _____

Do you have any medical problems? Y / N If Yes, please list: _____

_ _____

_____

SURGERY

Have you had any surgeries? If YES, PLEASE list and provide dates: _____ _____/_____/_____

_____ _____/_____/_____ _____ _____/_____/_____

_____ _____/_____/_____ _____ _____/_____/_____

SOCIAL HISTORY

◯ ◯ ◯

___ # of children Do you smoke tobacco? Y / N / former smoker If YES how many years __ and ___# packs per day

Alcohol use: ☐ none, ☐ social, _____ # of drinks per week

◯ ◯

Have you ever been treated for chemical dependence? Yes / No

Education (highest level achieved) ☐ elementary school ☐ high school ☐ technical ☐ college ☐ advanced degree

FAMILY MEDICAL HISTORY **PLEASE LIST ANY FAMILY HISTORY OF ILLNESS**

MOTHER _____

FATHER _____

SISTERS _____

BROTHERS _____

REVIEW OF SYSTEMS: HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS SINCE THE ONSET OF YOUR ORTHOPAEDIC PROBLEM(S):

☐ CHEST PAIN	☐ UPSET STOMACH	☐ FRACTURE
☐ HEART PALPATION	☐ GI DISTRESS	☐ LOW BACK PAIN / SCOLIOSIS
☐ IRREGUALR HEART RATE	☐ NAUSEA / VOMITING	☐ NUMBNESS / WEAKNESS
☐ SHORTNESS OF BREATH	☐ DIARRHEA	☐ LEG / ANKLE SWELLING
☐ DIFFICULTY BREATHING	☐ BLEEDING PROBLEM/ BRUISING	☐ INFECTION
☐ LOSS OF CONSCIOUSNESS	☐ URINARY PROBLEMS	☐ DIFFICULTY HEARING
☐ FAINTING	☐ DIFFICULTY WITH URINATION	☐ VISUAL CHANGES
☐ DIZZINESS	☐ JOINT PAIN / SWELLING	☐ RASHES / SKIN INFECTIONS
☐ ABDOMINAL PAIN	☐ JOINT SPRAIN / MUSCLE STRAIN	☐ EMOTIONAL / ANIEXTY DISORDERS
☐ DIFFICULTY WITH SWALLOWING	☐ DISLOCATION / SEPARATION	_____ OTHER

_____ DOCTOR SIGNATURE _____ DATE