



St. Vincent's Orthopedics, P.C.

NAME		AGE	DATE OF BIRTH / /		
CHIEF COMPLAINT					
WHY ARE YOU SEEING THE DOCTOR?					
WAS THIS AN:	ON THE JOB INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF INJURY/ONSET / /	
PRESENT HISTORY: WHEN, WHERE, HOW, PREVIOUS TEST OR TREATMENTS?					

MEDICAL/SURGICAL HISTORY	
PLEASE LIST ALL PAST OR PRESENT MEDICAL OR SURGICAL CONDITIONS	
MEDICATIONS YOU CURRENTLY TAKE	
ALLERGIES TO DRUGS	

SOCIAL HISTORY			
TOBACCO USE <input type="checkbox"/> YES <input type="checkbox"/> NO _____ PACKS PER DAY	ARE YOU PRESENTLY UNDERGOING ANY DRUG OR ALCOHOL TREATMENT <input type="checkbox"/> YES _____	ALCOHOL USE <input type="checkbox"/> YES <input type="checkbox"/> NO _____ AMOUNT PER DAY	

REVIEW OF SYSTEMS	
PLEASE CHECK AND EXPLAIN ALL THAT APPLY	
HEAD AND NECK: Eye disease <input type="checkbox"/> yes _____ Ear disease <input type="checkbox"/> yes _____ Chronic sinus <input type="checkbox"/> yes _____ Other _____	GENITOURINARY: KIDNEY AND BLADDER - Chronic infections <input type="checkbox"/> yes _____ Kidney disease <input type="checkbox"/> yes _____ Bladder disease <input type="checkbox"/> yes _____ Prostate disease <input type="checkbox"/> yes _____ Other _____
CARDIORESPIRATORY: HEART AND LUNGS - High blood pressure <input type="checkbox"/> yes _____ Heart attack <input type="checkbox"/> yes _____ Heart failure <input type="checkbox"/> yes _____ Angina or chest pain <input type="checkbox"/> yes _____ Irregular heart beat <input type="checkbox"/> yes _____ Heart murmur <input type="checkbox"/> yes _____ Mitral valve prolapse <input type="checkbox"/> yes _____ Asthma <input type="checkbox"/> yes _____ Emphysema/COPD <input type="checkbox"/> yes _____ Other _____	ENDOCRINE: Diabetes <input type="checkbox"/> yes _____ Thyroid <input type="checkbox"/> yes _____ Other _____
GASTROINTESTINAL: STOMACH AND INTESTINES - Ulcers <input type="checkbox"/> yes _____ Hiatal hernia <input type="checkbox"/> yes _____ Liver disease <input type="checkbox"/> yes _____ Gallbladder disease <input type="checkbox"/> yes _____ Hepatitis or jaundice <input type="checkbox"/> yes _____ Other _____	MUSCULOSKELETAL: BONES AND JOINTS - Rheumatoid arthritis <input type="checkbox"/> yes _____ Osteoarthritis <input type="checkbox"/> yes _____ Arthritis - other <input type="checkbox"/> yes _____ Muscle disease <input type="checkbox"/> yes _____ Broken bones <input type="checkbox"/> yes _____ Other _____
CANCERS: <input type="checkbox"/> yes _____	NEUROLOGICAL: BRAIN AND NERVES - Epilepsy or seizures <input type="checkbox"/> yes _____ Strokes <input type="checkbox"/> yes _____ Other _____
	BLOOD: Anemia (low blood) <input type="checkbox"/> yes _____ Free bleeder <input type="checkbox"/> yes _____ Presently on any blood thinners <input type="checkbox"/> yes _____ Other _____

SIGNED: _____

DATE: ____/____/____