

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Reason for today's visit (brief description of onset):  
\_\_\_\_\_  
\_\_\_\_\_

Date of Injury or onset of problem: \_\_\_\_\_ Was this related to an auto accident? Yes No

Work Related: Yes No

Affected side: Left Right Dominant hand: Left Right

What is your occupation \_\_\_\_\_

Have you had X-rays taken? Yes No Have you had an MRI? Yes NO If yes, where? \_\_\_\_\_

**Drug Allergies:** Yes No Please list drug and reaction \_\_\_\_\_

Daily Medications: (please include pain meds, herbs vitamins & OTC)  
Name Dose/Strength Times per Day

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History: (list type and date)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Medical/Hospital History: (illnesses/conditions)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you now have or have you ever had

Anemia.....	Yes	No
Diabetes.....	Yes	No
Cancer/Type.....	Yes	No
Kidney/Bladder Trouble.....	Yes	No
High Blood Pressure.....	Yes	No
Heart Trouble. Type.....	Yes	No
Bleeding Disorder.....	Yes	No
Asthma.....	Yes	No
Neurological Disorders/Seizures.....	Yes	No
Depression.....	Yes	No
Stroke.....	Yes	No
Thyroid Disorder.....	Yes	No
Ulcer/Stomach Problems.....	Yes	No
Hepatitis: Type.....	Yes	No
Arthritis/Gout.....	Yes	No
Phlebitis/Blood Clots.....	Yes	No

Do you exercise? Yes No (running, biking, walking, cardio, weights etc) How often? \_\_\_\_\_

What type: \_\_\_\_\_

Do you smoke? Yes No Packs per day? \_\_\_\_\_

For how many years? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, average consumption per week \_\_\_\_\_

Are you now or could possibly be pregnant? Yes No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? Yes No If yes, who and what is their age:  
\_\_\_\_\_  
\_\_\_\_\_

Have you or any blood relative younger than 50 ever had a serious reaction to anesthesia? Yes No

If yes, who and what is their age?  
\_\_\_\_\_  
\_\_\_\_\_

**The above information is to the best of my knowledge a true statement of my current condition.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_