

**ARIZONA ORTHOPEDIC & FRACTURE SURGEONS
CURRENT INJURY OR PROBLEM**

PATIENT NAME _____ **Date of Birth** _____
REFERRED BY: _____ **FAMILY DOCTOR** _____
CURRENT PROBLEM _____ **RIGHT LEFT** _____
DATE OF INJURY _____ **DATE OF FIRST SYMPTOMS** _____
HOW OCCURRED _____ **WHERE** _____
WORK RELATED YES NO **XRAYS TAKEN** _____ **WHERE** _____
ARE YOU? RIGHT LEFT HANDED **ARE YOU PREGNANT?** YES NO

**PAST MEDICAL HISTORY
CIRCLE ALL THAT APPLY**

EYES	DATE OF DIAGNOSIS	GASTROINTESTINAL CONT'D	DATE OF DIAGNOSIS
Cataracts		Cirrhosis	
Glaucoma		Ulcers	
Lens implants		Colitis	
Other		Abdominal Pain	
ENT		Other bowel problems	
Hearing Problems		GENITOURINARY	
Frequent ear, nose, throat infections		Prostate Problems	
Other		Difficulty urinating	
CARDIAC/CIRCULATORY		Kidney stones/disease/failure	
High Blood Pressure		Sexually transmitted disease	
Heart Attack		Gout	
Chest Pain/Angina		Other	
Irregular Heartbeat		IMMUNOLOGY	
Palpitations		Lupus	
Pacemaker/abnormal heart valve		Rheumatoid arthritis	
Leg swelling/edema/phlebitis		Other	
Varicose Veins		BLOOD/HEMATOLOGIC	
High Cholesterol		Anemia	
Other		Bleeding disorder	
PULMONARY/RESPIRATORY		Other	
Emphysema		ENDOCRINE	
Chronic Bronchitis/COPD		Thyroid problems	
Asthma, chronic cough/sputum		Diabetes:	
Valley Fever/TB		Do you check your sugar? YES NO	
Other		How often? Daily Weekly	
SKIN		High Low Bloodsugar	
Psoriasis, rash,		GENERAL	
Other		Fever/chills//head ache/vision changes	
NEUROLOGIC		Unexplained weight loss/gain/nausea/vomiting	
Parkinson's		Cancer: colon,lung,kidney,breast	
Multiple Sclerosis		thyroid,prostate,Other	
Stroke/TIA		PSYCHIATRIC	
Paralysis		Depression	
Numbness/tingling-arms or legs		Schizophrenia	
Seizure Disorder		Bipolar disorder	
Other		ABDH	
GASTROINTESTINAL		Eating disorder	
Hepatitis- type A B C		Other	

PAST MEDICAL HISTORY CONTINUED
CIRCLE ALL THAT APPLY

<u>PAST SURGICAL HISTORY</u>	<u>DATE</u>	<u>SOCIAL</u>	
		Occupation	
		Marital Status S M D W	
		Alcohol use: Daily Weekly Never	
		Quantity:	Years:
		Tobacco: YES NO How much?	
		How long?	Year quit
<u>FAMILY HISTORY/AGE/ILLNESSES</u>	<u>DATE</u>	<u>MEDICATIONS YOU ARE TAKING;</u>	<u>DATE</u>
<u>ALLERGIES FOOD/DRUGS-REACTION</u>	<u>DATE</u>	HEIGHT: _____ WEIGHT: _____	
		<i>OTHER:</i>	

PATIENT (OR GUARDIAN) SIGNATURE

DATE