CONCORD ORTHOPAEDICS PROFESSIONAL ASSOCIATION

Name: _____ Date of Birth: _____ Today's Date: _____

Height: _____ Weight: _____ Date of Injury: _____

Primary Care Physician: _____ Address _____

Who recommended this office? _____ Address _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____ ☐ Right ☐ Left or ☐ Both

Current problem is the result of a(n): *Check* all that apply

☐ Car Accident ☐ Work Accident ☐ Slip & Fall Accident ☐ Other: _____

Have you had Physical Therapy for this problem? ☐ No ☐ Yes, Where? _____

PAST MEDICAL HISTORY

Do you or have you ever had: (Circle)

Cancer	Leukemia	Epilepsy	Migraine	Pneumonia	Stroke	Depression	Anxiety
Jaundice	Psoriasis	Asthma	Cataracts	Colitis	Anemia	Polio	Diabetes
High Cholesterol	Thyroid Problems	Rheumatic Fever	Kidney Disease	Stomach Ulcers	High blood Pressure	Previous Transfusions	Heart Problems
Hepatitis	Other:						

PAST SURGICAL HISTORY

Surgeries/Hospitalizations	Year	Complications/Problems with anesthesia

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother(Mom's)	A	D		
Grandfather(Mom's)	A	D		
Grandmother(Dad's)	A	D		
Grandfather(Dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

MEDICATION

Medication	Dose	Reason for Medication	Side Effects

IMPORTANT: PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM!

ALLERGIES

Do you have any latex allergies? ☐ No ☐ Yes

Any known medication allergies? ☐ No ☐ Yes, Please List:

Name	Reaction

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	Circle		Describe all YES responses
Eyes	No	Yes	
Ears,Nose Throat	No	Yes	
Lungs, Breathing	No	Yes	
Digestion/Bowel movement	No	Yes	
Bladder problem	No	Yes	
Bleeding problems	No	Yes	
Skin/ rashes, lesions, etc.	No	Yes	
Muscle Problems	No	Yes	
Joint problems	No	Yes	
Numbness/tingling	No	Yes	
Blackout/fainting	No	Yes	
Psychological Problems	No	Yes	
Arthritis	No	Yes	
TB	No	Yes	
Chest pain/irregular heartbeat	No	Yes	
AIDS	No	Yes	

Patients under 18: Birth Weight:_____ Pregnancy Duration: _____ Breech? ☐ No ☐ Yes

List any pregnancy complications: _____

Scoliosis Patients: Neck and headaches ☐ No ☐ Yes Incontinence ☐ No ☐ Yes

Girls: First menstrual period:_____

SOCIAL HISTORY

☐ Work in the home ☐ Employed (occupation_____) ☐ Student ☐ Retired

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ No ☐ Yes How many?_____ Do you live alone? ☐ No ☐ Yes

Exercise? ☐ Daily ☐ 2-3 Times/Week ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of exercise?_____

History of substance abuse? ☐ No ☐ Yes What?_____

Smoke currently? ☐ No ☐ Yes ____Packs per day____years,

Quit smoking? ☐ This year ☐ >1 year ☐ >5 years ☐ >10 years, Previously smoked____ Packs per day for _____years

Drink alcohol? ☐ Daily ☐ 1 – 2 x/week ☐ 1-2 x/month ☐ 1-2 x/year

_____ _____

Patient's/Parent's/Guardian's Signature Date

_____ _____

Physician's Signature Date