ORTHOBETHESDA

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CLINICAL INFORMATION SHEET - Your insurance company **requires** that we obtain this information. Please fill out **completely!**

PATIENT'S NAME _____ HEIGHT_____ ft. _____ in. WEIGHT_____ AGE_____

GENDER_____ **IF FEMALE:** IS THERE ANY POSSIBILITY THAT YOU ARE ***PREGNANT***? ☐ Yes ☐ No

PRIMARY CARE (REFERRING) **PHYSICIAN** _____ REFERRING **PHYSICIAN** IF DIFFERENT _____

WE WILL SEND OFFICE NOTES TO THE ABOVE PHYSICIANS UNLESS OTHERWISE DIRECTED

ARE YOU STAYING AT A SKILLED NURSING FACILITY? ____ WHERE? _____ PHONE:_____

MEDICAL HISTORY: Please circle if you have, or have had, any of the following: ☐ NONE

1. Diabetes	5. Heart Arrhythmia	9. Heart Attack	13. Rheumatoid Arthritis	17. Stomach/Duodenal Cancer
2. Stroke	6. Coronary Heart Disease	10. High Cholesterol	14. Liver Disease	18. Gastro/Esoph/Acid Reflux
3. TIA (mini stroke)	7. High Blood Pressure	11. Depression	15. Kidney Disease	19. Pacemaker
4. Osteoarthritis	8. HIV/AIDS	12. Hepatitis	16. Cancer (type):_____	

OTHER _____

SURGICAL PROCEDURES: Have you ever had any surgery? ☐ YES ☐ NO If yes, please circle:

1. Heart Surgery	3. Vascular Bypass	5. Angioplasty	7. Appendectomy	9. Carotid Endarterectomy
2. Hernia Repair	4. Hysterectomy	6. Cancer Surgery_____	8. Gallbladder Surgery	Date of Surgery:_____

Please list any ***orthopaedic surgeries*** you have had: _____

REVIEW OF SYMPTOMS: Are you currently having, or have you ever had, problems with: ☐ NONE

Lungs or Breathing? ☐ Yes ☐ No Bleeding Disorders? ☐ Yes ☐ No Heart or Chest Pain? ☐ Yes ☐ No
GI Ulcers? ☐ Yes ☐ No Numbness or Tingling? ☐ Yes ☐ No

SOCIAL HISTORY:
Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you exercise regularly? ☐ Yes ☐ No

MEDICATIONS: Do you take any medications, including aspirin and other non-prescription medications? ☐ Yes ☐ No
If yes, please list: _____

_____

ALLERGIES: Are you allergic to any medications, environmental substances, or metals? ☐ Yes ☐ No If yes, please list.

_____

WHAT PART OF THE BODY ARE YOU HERE FOR TODAY? _____ ☐ LEFT ☐ RIGHT
WHEN DID THIS PROBLEM BEGIN?* _____

*IF ONGOING, PLEASE INDICATE TIME PERIOD OF MOST RECENT EPISODE OR "FLARE-UP:"

_____

WAS THERE A SPECIFIC INJURY? ☐ Yes ☐ No **If yes, briefly describe incident: HOME WORK OTHER**
_____

PAST HISTORY – Have you had previous problems with this area? ☐ Yes ☐ No
If yes, please describe: _____

HAVE YOU SEEN ANY OTHER PHYSICIANS FOR THIS PROBLEM? ☐ Yes ☐ No Physician_____

WERE X-RAYS TAKEN? ☐ Yes ☐ No IF YES, DID YOU BRING THE X-RAYS WITH YOU? ☐ Yes ☐ No

WERE ANY OTHER TESTS PERFORMED? ☐ Yes ☐ No IF YES, DID YOU BRING THE TEST RESULTS WITH YOU? ☐ Yes ☐ No

***** The above is true and correct to the best of my knowledge.
PATIENT SIGNATURE _____ **DATE** _____

REVIEWED BY_____ DATE _____