Name:
Chart:
Date: DOB:

ADVANCED Orthopaedics & Rehabilitation

Ref. By: _____ Height: _____
Occupation/Job duties: _____ Weight: _____
Are you Right or Left hand dominant? ☐ Right ☐ Left Age: _____
Please describe to us the reason for your visit: (include onset of symptoms, location, severity, duration)

_____

_____

Was there an injury? ☐ Yes ☐ No Date of Injury: ____/____/____
If yes, please describe: _____

_____

Do you have any metal in your body? ☐ Yes ☐ No Where? _____
Do you weld or grind metal? ☐ Yes ☐ No

Do you have or have you had any of the following? (Please place a checkmark in front of the problem)

☐ Asthma
☐ Anemia
☐ Arthritis Where? _____
☐ Artificial Joint Which joint(s)? _____
_____
☐ Blood clot
☐ Blood diseases
☐ Blood transfusion
☐ Cancer: List type _____
☐ Chemotherapy/Radiation
☐ Circulatory Problems
☐ Diabetes
☐ Do you wear contact lenses? ☐ Yes ☐ No
☐ Epilepsy/seizures
☐ Excessive bleeding
☐ Glaucoma
☐ Heart disease/Attack
☐ Heart murmur
☐ Heart Valve Replacement
☐ Hepatitis/jaundice/liver disease
☐ AIDS/HIV exposure

☐ Claustrophobia
☐ High Blood Pressure
☐ Kidney Stones
☐ Urinary disease
☐ Lung clot
☐ Osteoporosis
☐ Pacemaker/Defibrillator
☐ Mental Illness
☐ Recent weight loss/gain
☐ Rheumatic Fever
☐ Sleep Apnea/Do you use a CPAP? ☐ Yes ☐ No
☐ Stroke
☐ Tuberculosis
☐ Ulcers
☐ Have you had a tetanus shot in the last ten years? ☐ Yes ☐ No

☐ Previous fractures? ☐ Yes ☐ No
R/L Which bone? _____
☐ Cholesterol

_____

Please list your family history of any problems listed above: Father _____ Mother _____
Brother _____ Sister _____ Son _____ Daughter _____
Previous Surgeries: _____

_____

Do you have any disease, problem, or condition not listed? _____

_____

Smoking Status:
☐ Never Smoker ☐ Former Smoker: Year Started _____ Year Quit _____
☐ Current Everyday Smoker Year Started _____ Packs per day _____
☐ Heavy Tobacco Smoker Year Started _____ Packs per day _____
☐ Light Tobacco Smoker Year Started _____ Packs per day _____
☐ Smoker, Current Status Unknown ☐ Unknown If Ever Smoked
Do you use chewing tobacco? ☐ Yes ☐ No
Do you consume alcoholic beverages? ☐ Yes ☐ No If yes, how often? _____

Patient Signature: _____ Date: _____