Orthopaedic Associates of Riverside

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Patient Name:_____ **Date of Birth:**_____

Age:_____ **Occupation:**_____ **Height**_____ **Weight**_____

Reason for today's visit:_____

_____

Duration of symptoms:_____ **Allergies:** _____

Current Medications:_____

_____

_____

Alcohol Use: YES NO **Tobacco use: YES NO**

Past Orthopaedic Problem(s):_____

_____

Previous Surgery:_____

_____

Family Medical History:_____

_____

Have you ever had any of the following? (Please check all that apply)

__ Heart Disease
__ Pacemaker
__ High Blood Pressure
__ HIV/AIDS
__ Circulatory Problems
__ Hemophilia
__ Artifical Heart Valves
__ High Cholesterol
__ Blood Clots/DVT
__ Afib
__ Epilepsy
__ Stroke
__ Nervous Problems
__ Psychiatric Care
__ Chemical Dependency
__ Depression
__ Sleep Apnea
__ Neuropathy
__ Respiratory Disease
__ Asthma
__ COPD
__ Rheumatic Fever
__ Recent Weight Loss
__ GI Bleeding
__ Acid Reflux
__ Recurrent UTIs
__ Chronic Diarrhea
__ Hypothyroidism
__ Kidney Disease
__ Hepatitis
__ Jaundice of Liver Disease
__ Radiation Treatment
__ Cancer
__ MRSA
__ Ulcer
__ Gout
__ Diabetes
__ Rheumatoid Arthritis
__ Back Problems
__ Osteoarthritis
__ Osteoporosis
__ Joint Replacement
__ Fibromyalgia
__ Alcohol Abuse
__ Drug Addiction

Signature of Patient or Guardian_____ **Date**_____