MOUNTAIN VALLEY ORTHOPEDICS, P.C

Patient Name: _____

Date of Birth:_____

***Referring Physician**:_____**Primary Medical Doctor:** _____

Chief Complaint:_____

How did the injury occur?_____**Date of Onset or Injury:**_____

Pharmacy Name & Location: _____

To be completed by medical staff

HT:_____**WT:**_____**BP:**_____**Pulse:**_____**Resp:**_____

Are you allergic to LATEX? ☐ **Yes** ☐ **No**

DRUG ALLERGIES ☐ **Yes** ☐ **No** **if yes please list medication allergy, reaction and severity below:**

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS & VITAMINS/Minerals: **Include name, dosage and directions.**

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY- Blood relatives with the following (Alive / Deceased PLEASE CIRCLE)

Family Member	Medical Problems
Mother: **Alive or Deceased**	☐ Diabetes (sugar) ☐ Hypertension ☐ Heart Problems ☐ Cancer ☐ Other: _____
Father: **Alive or Deceased**	☐ Diabetes (sugar) ☐ Hypertension ☐ Heart Problems ☐ Cancer ☐ Other: _____
Sisters: **Alive or Deceased**	☐ Diabetes (sugar) ☐ Hypertension ☐ Heart Problems ☐ Cancer ☐ Other: _____
Brothers: **Alive or Deceased**	☐ Diabetes (sugar) ☐ Hypertension ☐ Heart Problems ☐ Cancer ☐ Other: _____

Social History/Social Habits: Check (✓) substances you have used.

☐ Tobacco ___Current Smoker____Previous Smoker_____Non Smoker

☐ Alcohol – if yes, how often_____

☐ Recreational Drugs/Steroid use? _____

☐ Occupation _____ ☐ **Left Handed** ☐ **Right Handed** ☐ **Ambidextrous**

SURGICAL HISTORY/HOSPITALIZATIONS:

YEAR	TYPE OF SURGERY/HOSPITALIZATION

MEDICAL HISTORY: Check (✓) if you have/had in the past ☐ **NOTHING BELOW APPLIES**

☐ Anemia
☐ Anesthesia problem
☐ Angina
☐ Anxiety Disorder
☐ Asthma
☐ Atrial Fibrillation
☐ Bleeding Disorder
☐ Cancer _____
☐ Carpal Tunnel
☐ COPD (asthma, emphysema)
☐ Crohn's Disease
☐ Depression
☐ Diabetes (Type I or II)
☐ Diverticulitis
☐ DVT (Blood clot)
☐ Emphysema
☐ Fibromyalgia
☐ Food Allergies
☐ Gout
☐ Hearing Loss
☐ Heart Attack (MI)
☐ Heartburn/Reflux/GERD
☐ Hepatitis
☐ High Cholesterol
☐ HIV/Aids
☐ Hypertension
☐ Kidney Disease
☐ Leg or Foot Ulcers
☐ Liver Disease
☐ Migraines
☐ Multiple Sclerosis
☐ Neuropathy
☐ Organ Transplant
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Peripheral Vascular Disease
☐ Pulmonary Embolism
☐ Rheumatoid Arthritis
☐ Seizures/Epilepsy
☐ Sleep Disorder
☐ Stents
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcerative Colitis
☐ Valve Replacement

REVIEW OF SYSTEMS: Check (✓) if you have or had in the past. ☐ NOTHING BELOW APPLIES

☐ Left Handed ☐ Right Handed ☐ NOTHING BELOW APPLIES

EYES
☐Blindness
☐Glaucoma
☐Blurred vision

EAR, NOSE, THROAT
☐Hearing loss
☐Ringing/buzzing in ears
☐Dentures
☐CA of Mouth/throat
☐Frequent/severe nosebleeds

CARDIOVASCULAR
☐Chest pain/tightness
☐Swelling in feet/ankles
☐Heart Murmur
☐Cramps in calves

RESPIRATORY
☐Constant/recurrent cough
☐Coughing up blood
☐Shortness of breath
☐Sleep apnea

GASTROINTESTINAL
☐Nausea
☐Constipation
☐Black or tarry stool
☐Vomiting

GENITOURINARY-MEN
☐Trouble urinating
☐Prostate enlargement
☐Hematuria

GENITOURINARY WOMEN-OB/GYN
☐Painful/burning urination
☐Trouble urinating
☐Hematuria
☐Post Menopause
Pregnant (for radiological use)
☐Yes ☐ No

MUSCULOSKELETAL
☐Back pain
☐Neck pain
☐Gait disturbance/Imbalance
☐Joint pain
☐Muscle Stiffness

INTEGUMENTARY/SKIN
☐Rashes
☐Itching
☐Growth/lesion
☐Jaundice

NEUROLOGICAL
☐Frequent headaches
☐Migraines
☐Restless legs
☐Dizziness/lightheadedness
☐Numbness/weakness/tingling of:
  ☐Upper extremities
  ☐Lower extremities

PSYCHIATRIC
☐Depression
☐Anxiety
☐Suicide thoughts

ENDOCRINE
☐Heat/cold intolerance
☐Increased thirst
☐Weight gain/Weight loss

HEMATO-IMMUNOLOGIC
☐Bruise easily
☐Bleeding problems
☐Recurrent infections

ALLERGIC/IMMUNOLOGIC
☐Chills/Fever
☐Night Sweats

Patient/Guardian Signature:_____ **Date:**_____