RIDGEWOOD ORTHOPEDIC GROUP L.L.C.

Today's Date: ___/___/___

Patient's Name: Last First M.I.	**Patient's Age:**

REFERRING / MEDICAL DOCTOR:____

WHY are you seeing the doctor today? ____

DO YOU HAVE ( )LEFT OR ( )RIGHT SIDED PAIN OR INJURY?_________ WHERE?______________________________

WHEN DID THIS HAPPEN OR START?____

WERE YOU SEEN IN THE EMERGENCY ROOM FOR THIS ( )YES ( )NO IF YES WHERE?_________________________

Please CHECK That Which Applies

( ) Automobile Accident ( ) Work-related Injury ( ) Miscellaneous Accidental Injury ( ) Other

Please Describe: ____

Did this happened while you were?... (CHECK All That May Apply)

( ) Lifting	( ) Reaching	( ) Pulling	( ) Squatting	( ) Pushing
( ) Twisting	( ) Falling	( ) Bending	( ) Hit by	( ) Not Known

List all MEDICATIONS which you are currently taking on a regular basis

Name of Medicine	Dose	How Long	Side Effects

<u>*****List Any ALLERGIES to PRESCRIPTION DRUGS:</u>____**

<u>***** Any INTOLERANCE to Over-the-counter DRUGS?</u>____**

Please indicate any current or past MEDICAL PROBLEMS by circling YES or NO

		If YES, please describe
EYES	No Yes	
EARS/ NOSE/ THROAT	No Yes	
LUNGS/ RESPIRATORY/APNEA	No Yes	
STOMACH/ DIGESTION	No Yes	
BOWELS/ INTESTINAL	No Yes	
BLADDER	No Yes	
DIABETES	No Yes	
BLOOD PRESSURE (High/ Low)	No Yes	
BLEEDING	No Yes	
BALANCE/ DIZZYNESS	No Yes	
BLACKOUTS/ FAINTING	No Yes	
NUMBNESS/ TINGLING	No Yes	
PSYCHOLOGICAL/ EMOTIONAL	No Yes	
AIDS/TUBERCULOSIS	No Yes	
CANCER	No Yes	
ARTHRITIS	No Yes	
POLIO	No Yes	
ENDOCRINE/THYROID	No Yes	
EPILEPSY/ SEIZURE DISORDER	No Yes	
STROKE/ HEART	No Yes	
MULTIPLE SCLEROSIS/ LUPUS	No Yes	
OTHER	No Yes	

REVIEWED BY: Dr.___________________________________ DATE: _____/_____/_____

Revised 11/6/2006

Name: Last First M.I.	Today's Date: ___/___/___

MEDICAL HISTORY

Have you ever had general anesthesia? ( ) NO ( ) YES If you had any problems with anesthesia, please describe: ____________________

Type of Hospital Illness or Surgery	Year	Any Complications

FAMILY HISTORY

Relationship	Still Alive (Please circle YES or NO)	Age	Health Status - OR - Cause of Death
Mom's Mother	YES NO		
Mom's Father	YES NO		
Dad's Mother	YES NO		
Dad's Father	YES NO		
Mother	YES NO		
Father	YES NO		
Sister or Brother	YES NO		
Sister or Brother	YES NO		
Sister or Brother	YES NO		
Sister or Brother	YES NO		
Sister or Brother	YES NO		

SOCIAL HISTORY

( ) EMPLOYED [occupation]____________________

( ) WORK AT HOME ( ) STUDENT ( ) PRE-SCHOOL

ARE YOU: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

DO YOU HAVE CHILDREN? ( ) No ( ) Yes How Many? _____

DO YOU LIVE ALONE? ( ) No ( ) Yes

DO YOU REGULARLY EXERCISE? ( ) Daily ( ) Weekly ( ) Monthly ( ) Rarely ( ) Never

IF YES, WHAT TYPE OF EXERCISE?____________________

ARE YOU ON A SPECIAL DIET? ( ) No ( ) Yes - Describe:____________________

ANY HISTORY OF SUBSTANCE ABUSE? ( ) No ( ) Yes - What kind? ____________________

DO YOU DRINK ALCOHOL? ( ) No ( ) Yes - How much, how often? ____________________

DO YOU CURRENTLY SMOKE? ( ) No ( ) Yes ______ packs per day for ______ years

IF YOU HAVE QUIT, HOW LONG HAS IT BEEN? ______ weeks ______ months ______years

HOW MUCH DID YOU USED TO SMOKE? ______ packs per day for ______ years

REVIEWED BY: Dr.____________________ DATE: _____/_____/_____

Revised 11/6/2006