

ORTHOPEDIC SCREEN - Please circle any of the following conditions you have had or now have.

Rheumatism; recurrent joint swelling or pain; dislocated joints; loose body in joint; torn cartilage or ligaments; severely injured or sprained joints; known arthritic condition; gout or joint infection; joint laxity; loss of joint motion or other abnormality involving joints.

Neck or back pain; ruptured disc or sciatica; spinal curvature or other spine abnormality; chest deformity.

Brittle or soft bones; osteoporosis; known bone cyst or bone infection.

Inherited or congenital abnormality of extremities, trunk or any other areas; amputations.

Bursitis; tendinitis; painful bone spurs; torn muscles or tendons.

Fractures and other serious injuries; Please list date and type: _____

PREGNANCY - Do you have reason to believe that you might be pregnant or are you pregnant at this time? _____

PAST HISTORY OF OTHER MEDICAL PROBLEMS - If you have had any operations, please list them and indicate the approximate date or your age at the time of the procedure.

If you have had or have any significant illnesses, please circle the condition or list if not included below.

Tension or migraine headache; heart trouble or rheumatic fever; heart murmur; bladder or kidney trouble; diabetes; neurological disease; poliomyelitis; epilepsy; tumor or cancer; respiratory illness; pneumonia or emphysema; tuberculosis; asthma.

Psoriasis or other skin disease; chronic alcoholism or other drug addiction; inguinal, diaphragmatic or other hernia; high blood pressure or stroke; phlebitis; peptic ulcer or pancreatitis; anemia; other blood disorder or bleeding problem or easy bruisability; mental or nervous disorder; liver or gallbladder trouble; jaundice; thyroid disorder; colitis; tropical disease; genital or gynecological conditions, other than listed:

ALLERGIES (INCLUDE ALL DRUG ALLERGIES). (List) _____

Right or Left Handed

R L (Circle One)

Please list all medicines or drugs (include birth control medication) which you are taking now or have already taken. Give dose and frequency.

(If necessary, please check bottle label or consult your pharmacist):

Drug or Medicine	Amount or Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate your approximate use or intake of the following:

Coffee _____ Tobacco Products _____

Alcoholic Beverages _____

Recreational Drugs _____

REVIEW OF SYSTEMS: Please draw a circle around any symptoms or conditions in this section which you have had or now have. If your symptoms or condition is not in the list, please write it in.

Eye & Vision - Loss of vision; eye pain or redness; excessive watering; double vision; other than listed: _____

Ear & Hearing - Loss of hearing; buzzing or noises in ears; ear infection or drainage; other than listed: _____

Nose & Throat: - Horseness; excessive sneezing; blocked nasal passages; nosebleeds; frequent running nose; difficulty swallowing; other than listed: _____

Respiratory - Wheezing; large quantity of sputum; blood sputum; excessive cough; shortness of breath with little exercise or at rest; night sweats; pain with breathing; other than listed: _____

Cardiovascular - Chest pain; abnormal or fast heartbeat; abnormally low blood pressure; calf cramps with walking; excessive sensitivity of fingers & toes to cold; varicose veins; frequent & marked swelling of ankles & feet; other than listed: _____

Gastrointestinal - Digestion difficulties; frequent nausea or vomiting; bloody vomitus; lack or loss of appetite; stomach or abdominal pain; frequent belching; frequent loose bowel movements; recurring diarrhea; blood in the stool; hemorrhoids or piles; gallbladder trouble; frequent or severe constipation; persistent anal itch; other than listed: _____

Genital-Urinary - Urinary incontinence or dribbling; bloody urine; increased frequency of urination; chronic urgency of urination; difficulty starting or passing urine; painful urination; narrowing of urinary stream; flank pain; excess urine; other than listed: _____

Genital-Urinary - (Male Patients) Penile pain, infection, or sores; abnormality of testicles; scrotal swelling; varicocele; prostatitis; stricture; sterility, difficulty in sexual functioning; other than listed: _____

Genital-Urinary - (Female Patients) Breast discharge, swelling, lumps, pain or infection; nipple changes or irritation; vaginal pain, infection, discharge or itch; known uterine fibroids or tumors; tubal infections; abnormality of menstrual flow; painful menses; infertility or difficulty in becoming pregnant; marked change in body hair distribution; difficulty in sexual functioning; other than listed: _____

Neurological - Severe or frequent headaches; unusual head or neck tension; dizziness; fainting spells; seizures; fits or convulsions; shaking or twitching spells; paralysis of limbs; frequent or constant numbness or tingling of parts of body; severe lapses of memory; blackouts; other than listed: _____

Emotional or Psychological - Emotional illness; depression; recurrent feelings of loneliness or hopelessness; excessive worry; severe tension; feelings of worthlessness; recurrent fear; nervous exhaustion; frequent crying; insomnia; nervous breakdown; frequent nightmares; hysterical attacks; constant unhappiness; other than listed: _____

Work Compensation Claim or Litigation Involving Illness or Injury. Prior, present, pending or anticipated: _____ Explain: _____

Attorney, if any: _____

Other Medical or Surgical Conditions Not Already Listed - Include hospitalizations not previously noted. (List): _____

FAMILY HISTORY: Please complete the following and enter all medical conditions of each person. Refer to List of Conditions under **Past History Section** and also add any orthopedic condition or symptoms that you now have and any member of your family has now or did have.

	Deceased or Living	Age Now or at Time of Death	Medical Conditions including Cause of Death, if deceased
Father			
Mother			
Brothers (List)			
Sisters (List)			
Children (List)			

Physician's Comments: