HARTFORD ORTHOPEDIC SURGEONS PC | ORTHO SPEEDPASS
Walk-In Urgent Orthopedic Care

Patient Name:_____ **Today's Date:**_____

Age:_____ **D.O.B:** _____

Reason for today's visit:_____

Height: _____ **Weight:** _____ **Date of Last Physical:** _____

Primary Care MD:_____ **Referred By:**_____

Allergies (please list): **Food:** _____
Metal: _____
Drugs: _____

Please list all physicians treating you at this time:		

Symptoms You are Currently Experiencing- Check for YES Leave Blank for NO

GENERAL	**EYES, EARS, NOSE & THROAT**	**GASTROINTESTINAL**
___ Chills	___ Blurred Vision	___ Poor Appetite
___ Depression/Anxiety	___ Difficulty Swallowing	___ Bowel/Bladder Changes
___ Fainting	___ Double Vision	___ Gas
___ Fever	___ Earache	___ Heartburn
___ Headache	___ Hoarseness	___ Nausea
___ Lack of Sleep	___ Loss of Hearing	___ Red Blood in Bowel
___ Recent Wgt Loss	___ Chronic Cough	___ Abdominal Pain
___ Night Sweats	___ Ringing in Ears	
___ Numbness	___ Sinus Pain	
CARDIOVASCULAR		**GENITO-URINARY**
___ Chest Pain	___ Palpitations	___ Bloody Urine
___ Ankle Swelling	___ Varicose Veins	___ Frequency
___ Low Bld Pressure	___ High Blood Pressure	___ Pain
SKIN	**MUSCULOSKELETAL/JOINT PAIN**	
___ Bruise Easily	___ Arms	___ Hip
___ Itching	___ Ankle	___ Knee
___ Skin Sores	___ Back	___Leg
	___ Feet	___ Shoulder
	___ Elbow	___ Hand/Wrist

Past Medical History- Please Check if you have any of the following- Leave Blank for NO

___ Alcoholism	___ Diabetes	___ Pacemaker
___ Anorexia	___ Emphysema	___ Pneumonia
___ Anemia	___ Gout	___ Polio/Typhoid
___ Arthritis	___ Glaucoma	___ Prostate Cancer
___ Asthma	___ Heart Disease	___ Psychiatric Disorders
___ Blood Disorder	___ Hepatitis	___ Pulmonary Embolism
___ Breast Lump/Mass	___ Hernia	___ TB
___ Bronchitis	___ High Cholesterol	___ Thyroid Disease
___ Cancer	___Liver Disease	___ Scarlet Fever
___ Cataracts	___ Migraines	___ Ulcers
___ Chemical Dependancy	___ MS	___ Any metal in your body, implants, eyes, etc.

Other:_____

OVER PLEASE

Family History - Mark M/F/B/S for Mother, Father, Sister, Brother

___ Arthritis	___ Asthma	___ Reaction to Anesthesia	___ Bleeding Problems
___ Cancer	___ Heart Disease	___ Depression	___ Diabetes
___ HIV	___ Hypertension	___ Renal Disorders	___ Sickle Cell Anemia
___ Sickle Cell Trait	___ Thyroid Disease	___ DVT/Pulmonary Embolism	

Social & Work History- Please check YES or NO

Smoking Status	**Alcohol**	**Coffee**	**Caffeine (Soft Drinks)**
___ Former Smoker	___ YES	___ Yes	___ YES
___ Never A Smoker	___ NO	___ NO	___ NO
___ Everyday Smoker	___ Drinks Per Day		
___ Packs Per Day	Type of Alcohol		

Drug Use

___ YES ___ IV

___ NO ___ Other

Occupational Concerns

___ Stress ___Exposure to Hazardous Materials

___ Heavy Lifting Occupation:_____

Blood Transfusion History

Have you ever had a Blood Transfusion? ____ YES ____ NO

PAST JOINT REPLACEMENT SURGERIES

RIGHT	YEAR	LEFT	YEAR
Total Knee Replacement		Total Knee Replacement	
Total Knee Revision		Total Knee Revision	
Total Hip Replacement		Total Hip Replacement	
Total Hip Revision		Total Hip Revision	
Total Shoulder Replacement		Total Shoulder Replacement	

Additional Past Surgeries

Surgical Procedures	Year

Fill Out ONLY if you take Coumadin/Warfarin

Who is managing your coumadin?
When do you have your labs drawn?
What lab do you use?

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or my doctors or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date: _____