Patient Name:____ **Todays Date:**________________

D.O.B:__________________ **Height:**____________ **Weight:**______________

Primary Care MD:___________________________________ **Referred By:**_________________________

(First & Last name)

Please List all physicians treating you currently:

NAME	SPECIALTY

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

GENERAL

___ Chills
___ Fainting
___ Fever
___ Headache
___ Lack of Sleep
___ Recent Wgt Loss
___ Night Sweats
___ Numbness

EYES, EARS, NOSE & THROAT

___ Blurred Vision
___ Difficulty Swallowing
___ Double Vision
___ Earache
___ Hoarseness
___ Loss of Hearing
___ Chronic Cough
___ Sinus Pain

GASTROINTESTINAL

___ Poor Appetite
___ Bowel changes
___ Heartburn
___ Nausea
___ Red Blood in Stool
___ Abdominal Pain

CARDIOVASCULAR

___ Chest Pain
___ Ankle Swelling
___ Palpitations
___ Varicose Veins

GENITO-URINARY

___ Bloody Urine
___ Frequency
___ Pain During Urination

SKIN

___ Bruise Easily
___ Itching
___ Skin Sores

MUSCULOSKELETAL / JOINT PAIN

___ Arms
___ Ankle
___ Back
___ Feet
___ Elbow
___ Neck
___ Hip
___ Knee
___ Leg
___ Shoulder
___ Hand
___ Wrist

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

___ Allergy to Anesthesia
___ Alcoholism
___ Anorexia
___ Anemia
___ Arthritis
___ Asthma
___ Blood Disorder
___ Breast Lump/Mass
___ Cancer-TYPE:_______________
___ Cataracts
___ Chemical Dependency
___ COPD/Bronchitis
___ Dementia
___ Depression/Anxiety
___ Diabetes- __ Type1 __Type2
___ Diverticulitis
___ Fibromyalgia
___ Gout
___ Glaucoma
___ Heart Disease
___ Atrial Fibrillation
___ Hepatitis
___ Heart Attack
___ High Blood Pressure
___ High Cholesterol
___ Liver Disease
___ MS
___ Pacemaker/Stent
___ Pneumonia
___ Pulmonary Embolism/DVT
___ Sleep Apnea
___ Stroke
___ TB
___ Thyroid Disease
___ Ulcers
___ GI Bleeding
___ Skin Infection/Cellulitis
___ Hospitalized for Infection

Family History
Family History of Pulmonary Embolism/DVT?:___ NO ___Yes Family Member:__________________

Social History- Please Check YES or NO

Nicotine Use	**Alcohol**	**Drug Use**
___ Never	___ YES	___ YES
___ Former	___ NO	Type:________________
___ Current Nicotine Use	___ Drinks Per Day	___ NO
TYPE:_________________		

Previous General Surgery		**Previous Orthopedic Surgery**	
Procedure	**Year**	**Procedure**	**Year**

PAST JOINT REPLACEMENT SURGERIES		
Total Knee Replacement: **RIGHT LEFT**	**Surgeon:**	**Date:**
Total Knee Revision: **RIGHT LEFT**	**Surgeon:**	**Date:**
Total Hip Replacement: **RIGHT LEFT**	**Surgeon:**	**Date:**
Total Hip Revision: **RIGHT LEFT**	**Surgeon:**	**Date:**
Total Shoulder Replacement **RIGHT LEFT**	**Surgeon:**	**Date:**

I Certify that the above information is correct to the best of my knowledge. I will not hold my provider 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:**________________________