Patient Name:____ **Todays Date:**________________
Date of Birth:__________________ **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
___ 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

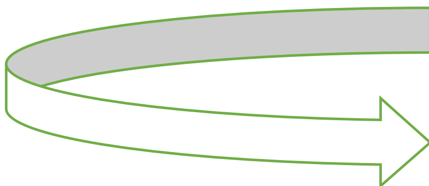
GENITO-URINARY
___ Bloody Urine
___ Frequency
___ Pain During Urination

SKIN
___ Bruise Easily
___ Itching
___ Skin Sores

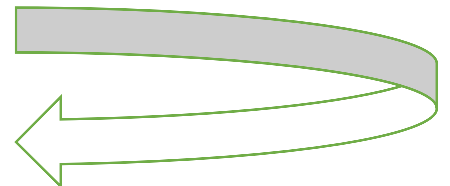
MUSCULOSKELETAL / JOINT PAIN
___ Arms
___ Ankle
___ Back
___ Feet
___ Elbow
___ Neck
___ Hip
___ Knee
___ Leg
___ Shoulder
___ Hand
___ Wrist

Past Medical History
___ 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

OTHER: ____



Please fill out the back of this page



Family History

Family History of Pulmonary Embolism/DVT/Blood Clots: ___ NO ___YES Relationship:_________________

Social History - Please Check YES or NO

Nicotine Use
___ Never
___ Former
___ Current Nicotine Use

TYPE:________________

Alcohol
___ NO
___ YES

___ Drinks Per Day/Week/Month
(circle one)

Drug Use
___ NO
___ YES

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:**______________________