The Orthopedic Group, PC **Today's Date:**

Name:_____ SS#:_____ Date of Birth:_____

Your PCP Name and Address:_____

Name and Address of Referring Physician:_____

Why are you seeing the doctor today?_____

IS YOUR PROBLEM THE RESULT OF SOME TYPE OF ACCIDENT?	YES NO
If YES, please check the type and date of accident below:	
( ) Work Place Accident Date of Accident:	Body Part(s) Involved:
( ) Auto Accident Date of Accident:	Body Part(s) Involved:
( ) Other Accident Date of Accident:	Body Part(s) Involved:

PAST MEDICAL HISTORY: Please list any previous surgeries or hospitalizations:

Surgery/Hospitalization	Date	Doctor/Surgeon	Hospital	Complication

Have you ever had general anesthesia? YES NO
Have you ever had any problems with anesthesia? YES NO If yes, describe:_____

MEDICATIONS: Please list any medications you are currently taking, including vitamins and herbal supplements:

Medication	Dosage/Frequency	Reason for Medication	Date Medication Started	Who Prescribed Medication?

HAVE YOU EVER TAKEN ANY TYPE OF ANTI-INFLAMMATORY MEDICATION? YES NO
If YES, Please list the medication, when taken, why taken, and any complications or side-effects: