



**Bone & Joint
Surgeons, Inc**

Today's Date _____

I am here to see: Sale Fidler Adkins
 Legg Pierson Castle Tanko

Reason for my visit _____

My name is: _____, _____, _____ My Birthdate Is _____
Last First MI

My Age Is _____

My Referring Dr. _____ My Primary Care Dr. _____

Other Doctors I am seeing: Dr. _____ for my _____

Dr. _____ for my _____ Dr. _____ for my _____

I consider my health good fair poor. I have or have had:

- | | | |
|---|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma/Ephysema/Black lung | <input type="checkbox"/> Diabetes - Insulin <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer - Where? _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcer/Reflux | <input type="checkbox"/> Blood Clots? - Where? _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Drug Dependency |
| <input type="checkbox"/> Anemia/Unusual Bleeding | <input type="checkbox"/> Kidney/Bladder/Prostate Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Stroke/Seizures | <input type="checkbox"/> Other _____ |

Medications I take (Prescription and Non-Prescription) - No Doses necessary See List Attached

_____ for _____; _____ for _____; _____ for _____
_____ for _____; _____ for _____; _____ for _____
_____ for _____; _____ for _____; _____ for _____
_____ for _____; _____ for _____; _____ for _____

I am allergic to or have had reactions to: _____

I smoke Yes No How much? _____ How long? _____ I drink alcohol Yes No How much? _____

I have had the following surgeries (type & year): _____, _____,

_____, _____ I had complication with _____ surgery.

I have been hospitalized in the past 5 years for: _____, _____,

_____, _____.

I have or recently have had:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Skin Rashes/Skin Ulcers |
| <input type="checkbox"/> Cold/flu symptoms | <input type="checkbox"/> Heart Irregularity | <input type="checkbox"/> Dark or Black Stool | <input type="checkbox"/> Recent Hair Loss |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg/Ankle Swelling | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Unplanned Weight Loss |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Coughing Up Blood | <input type="checkbox"/> Burning with Urination | <input type="checkbox"/> Generalized Weakness |
| <input type="checkbox"/> Recent Vision Change | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Frequent Nose bleeds | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Other _____ |

My Height is: _____ My Weight is: _____ Signed: _____

Additional Information or Pertinent family history on back. **Relation if Not Patient** _____