

**NORWICH ORTHOPEDIC GROUP, P.C.**

B/P and pulse: \_\_\_\_\_

Name: \_\_\_\_\_

Height: \_\_\_\_\_

Primary Care Doctor (Medical): \_\_\_\_\_

Weight: \_\_\_\_\_

List any specialists you see: \_\_\_\_\_

B.M.I.: \_\_\_\_\_

MEDICAL/SURGICAL HISTORY		YES	NO			YES	NO
<b>Any ALLERGY to medication, contrast dye, food?</b> <i>(Record type of reactions)</i> _____ _____ _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurological / Mental Health problems? (if yes, circle)</b> Stroke                      Seizures Multiple Sclerosis        Brain Injury Parkinson's Disease      Alzheimer's Disease Depression                Anxiety / Panic Attacks Other _____		<input type="checkbox"/>	<input type="checkbox"/>
<b>ALLERGY to LATEX</b> _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>Hearing or vision problems? (if yes, circle)</b> Hearing loss                Visual loss Glaucoma                    Cataracts Other _____		<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiac / Vascular problems? (if yes, circle)</b> Angina / Chest Pain      Heart Attack Heart Murmur              Mitral Valve Prolapse Irregular Rhythm         High Cholesterol High Blood Pressure      Poor Circulation Blood Clots (Phlebitis)(DVT) Pulmonary Embolism Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>Infectious / Immune System problems? (if yes, circle)</b> Cancer                      HIV / AIDS Rheumatoid Arthritis      Lyme Disease Lupus                        Fever/ Chills MRSA                        VRE Other _____		<input type="checkbox"/>	<input type="checkbox"/>
<b>Pulmonary problems? (if yes, circle)</b> COPD / Emphysema        Asthma Tuberculosis                Bronchitis / Pneumonia Sleep / Apnea Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>Prosthesis/Implanted/External Devices? (if yes, circle)</b> Pacemaker                  Defibrillator Artificial Limb              Ostomy Electric Stimulator        Heart Valve Other _____		<input type="checkbox"/>	<input type="checkbox"/>
<b>Abdominal problems? (if yes, circle)</b> GERD / Reflux              Hiatal Hernia Gastritis/Ulcers            Abdominal Pain Colitis                        Irritable Bowel Hepatitis / Jaundice        Cirrhosis Pancreatitis                 Gallstones Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>Previous procedures &amp; operations? (if yes, list)</b> _____ _____ _____		<input type="checkbox"/>	<input type="checkbox"/>
<b>Kidney or Bladder problems? (if yes, circle)</b> Renal Insufficiency        Kidney Stones Recurrent Infection        Enlarged Prostate Kidney Transplant         Incontinence Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>SOCIAL HISTORY</b> <b>Are you a smoker?</b> _____ # Packs/day		<input type="checkbox"/>	<input type="checkbox"/>
<b>Hormonal / Metabolic problems? (if yes, circle)</b> Diabetes                    Thyroid Disorder Anemia                        Bleeding / Clotting Disorder Weight Loss Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>Alcohol use? (please circle one)</b> None   Rare   Social   Regular		<input type="checkbox"/>	<input type="checkbox"/>
<b>If female, pregnant?</b> Date of last menstrual cycle? _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you use street or recreational drugs?</b> _____		<input type="checkbox"/>	<input type="checkbox"/>
				<b>FAMILY HISTORY</b> Cancer                      Diabetes                      Joint Disease Tuberculosis                Heart Disease                Disability High Blood Pressure        DVT (Blood Clots) Other _____			

List your current MEDICATIONS/ Include dosage and frequency /Include aspirin, anti-inflammatories, blood thinners, dietary supplements


Completed by patient? \_\_\_\_\_ Yes                      or Person Completing: \_\_\_\_\_

Information reviewed by clinical staff: Date / Initials \_\_\_\_\_ Revised Date / Initials: \_\_\_\_\_