OPA ORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

Pt. Label

Patient Medical History

Patient Name: _____ Date of Birth: ____/____/____
Last First Middle Initial

Language: _____ Gender: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Retired? ☐ No ☐ Yes

Primary Care Physician: _____ Referred By: _____

Date of Last Physical _____ Is this a work related injury? ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widow/er ☐ Dependent ☐ Domestic Partner

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Prefer not to disclose ☐ Unknown ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose ☐ Unknown

Preferred Pharmacy & Location: _____

Personal Medical History

(Please check if YOU currently have or had the following diseases/conditions and check any that apply.)

- ☐ Glaucoma
- ☐ Epilepsy/Seizures/Convulsions
- ☐ Stroke/TIA
- ☐ High Blood Pressure
- ☐ Heart Problems/Heart Attack/ Irregular Heartbeat
- ☐ DVT/Pulmonary Embolism/ Blood Clots
- ☐ Anemia/Bleeding Disorder
- ☐ Asthma/COPD/Emphysema/ Breathing Problems
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Liver Diseases/Hepatitis Type: _____
- ☐ Kidney Disease/Kidney Stones
- ☐ Prostate Disease
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis/Osteopenia
- ☐ Cancer Type: _____
- ☐ Communicable Diseases
- ☐ Tuberculosis
- ☐ Antibiotic Resistant Infection/ MRSA
- ☐ Anxiety/Depression
- ☐ HIV
- ☐ Steroid Use
- ☐ Metal Allergy
- ☐ Anesthesia Difficulties/ Malignant Hyperthermia
- ☐ Continuous Positive Airway Pressure (CPAP)
- ☐ Other: _____
- ☐ None

Previous Surgeries

(Please list ALL previous surgeries and date.)

Procedure/Date ☐ None	Procedure/Date
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Medications

(Please list ALL medications including prescriptions, over-the-counter medications and blood thinning medications such as Coumadin, Plavix, aspirin, etc.)

Medication ☐ None	Dose	How Often
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

Allergies

(Please list ALL allergies including contrast dyes, metal, latex, medication or other.)

Name — Specify Reaction (hives, rash, breathing difficulty, anaphylaxis)

☐ None

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Family History

(Please check if anyone in your FAMILY has or had the following diseases/conditions; check the applicable condition and list your relationship.)

☐ Glaucoma _____
☐ Epilepsy/Seizures/Convulsions _____
☐ High Blood Pressure _____
☐ Heart Problems/Heart Attack/Irregular Heartbeat/ Stroke _____
☐ DVT/Pulmonary Embolism/Blood Clots _____
☐ Anemia/Bleeding Disorder _____
☐ Asthma/Breathing Problems/Emphysema _____
☐ Diabetes _____
☐ Thyroid Disorder _____
☐ Liver Diseases/Hepatitis, Type: _____
☐ Kidney Problems _____
☐ Arthritis _____
☐ Gout _____
☐ Osteoporosis/Osteopenia _____
☐ Cancer, Type: _____
☐ Metal Allergy _____
☐ Other: _____
☐ None

Social History

Do you use tobacco? ☐ No ☐ Yes Packs Per Day: _____ If Quit, When: _____

Do you drink alcohol? ☐ No ☐ Yes How Much/Often: _____ If Quit, When: _____

Current or history of drug use? ☐ No ☐ Yes Type: _____ If Quit, When: _____

Are you pregnant? ☐ No ☐ Yes ☐ Possibly

How many children do you have? _____ Number living with you? _____

Review of Systems

(Please check if YOU are experiencing any of the following symptoms and check any that apply.)

☐ Fever
☐ Weight Loss or Gain
☐ Chills
☐ Fatigue
☐ Sore Throat
☐ Difficulty Swallowing
☐ Nose Bleeds
☐ Ear or Hearing Problems
☐ Headache
☐ Migraines
☐ Excessive Thirst or Appetite
☐ Excessive Urination
☐ Heat or Cold Intolerable
☐ Visual Difficulty
☐ Redness
☐ Watery Eyes
☐ Chest Pain
☐ Palpitations
☐ Fainting
☐ Murmurs
☐ Cough
☐ Sputum Production
☐ Snoring
☐ Short of Breath
☐ Wheezing
☐ Blood in Stool
☐ Loss of Bowel Control
☐ Nausea
☐ Vomiting
☐ Ulcers
☐ Urological Problems
☐ Painful Urination
☐ Prostate Problems
☐ Bleeding Problems
☐ Easy Bruising
☐ Joint Swelling
☐ Stiffness
☐ Heat
☐ Muscle Pain
☐ Swelling
☐ Depression
☐ Nervousness
☐ Anxiety
☐ Hallucinations
☐ Skin Disorders
☐ Rash
☐ Poor Healing

Pt. Label

The above information is true and correct to the best of my knowledge.

Patient Signature _____ Date _____

M.D. Review _____ Date _____