OPA ORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

Pt. Label

Patient Medical History

Patient Name: _____ (Last) _____ (First) _____ (Middle Initial)

Date of Birth: ____/____/____ 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 Language: _____

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 _____