New Patient Forms

Thank you for choosing Orozco Orthopaedics. Welcome to our practice.

Attached you will find two medical history forms to complete for your medical history intake. Once you arrive at the office you will need to initial and sign our new patient acknowledgement of office practice and policies that can also be found on our website in our New Patient Packet. You will confirm that your demographics are correct. For example that your name, dates, addresses, phone numbers, and insurance information is correct.

You can print these forms and bring them to your office visit. Please bring your insurance cards and a photo ID to your appointment.

Patient Health History Form

PLEASE PRINT ALL INFROMATION

NAME:	DOB:
What is your approximate weight? _______ Lbs.	Height?______ ft ______in
Referred here by: (circle one) self family friend doctor attorney internet search insurance co. other	
Name of Person / Physician making referral:	
List Current Treating Physicians including PCP:	
Describe the reason for your visit:	
Body Part to be examined: Right Left Both	
How did your symptoms/injury begin? (Describe in detail)	
Approximate date symptoms began or date of injury: New or Old injury (circle one)	
On a scale of 1-10 (10 being most severe) circle the # that best describes your pain: 1 2 3 4 5 6 7 8 9 10	
Resulting from: (circle which applies) Work Related Involving Litigation Auto	
Are Symptoms: constant intermittent worsening improving unchanged	
Circle all that apply pain stiffness swelling instability weakness numbness/tingling	
What makes symptoms worse?	
What makes symptoms better?	
What previous formal treatment have you had for this problem? (Medications, therapy, surgery, injections)	
PAST SURGICAL HISTORY Previous Type of Operation and Year 1. 2.	3. 4. 5.
Any previous fractures? YES NO WHERE?	
**DO YOU HAVE ANY DRUG ALLERGIES? ** (circle one) YES NO If yes, name the drug and describe the reaction, please be specific. (Example: rash, nausea, etc)	
CURRENT MEDS: (List any medications you are taking currently. Include items such as aspirin, vitamins, etc. NAME OF DRUG REASON FOR USE DOSING INSTRUCTIONS (strength & frequency)	
1. 2. 3. 4. 5.	6. 7. 8. 9. 10.

MEDICAL HISTORY/ REVIEW OF SYSTEMS			
Please check if you have a history of any of the following. **CHECK ONLY THOSE THAT APPLY**			
	GENERAL		**CARDIOVASULAR**
	Are you currently pregnant?		Pacemaker/ Defibrillator
	Diabetes – type I type II		Heart Attack/ Myocardial Infarction
	Stroke Palpitations		High Blood Pressure/ Hypertension
	Kidney Disease		Coronary Artery Disease
	Ulcers		Swelling of Lower Extremities
	Asthma or lung disease		**HEMATOLOGIC**
	Cancer: Type?		Anemia
	Fatigue		Blood Clots
	Weakness		Bleeding Tendency
	Fevers Bleeding Tendency		Easily Bruised
	Skin problems/disorders		Circulatory Problems
	Rheumatic Fever		Currently on Blood Thinners Type:
	Tuberculosis		**MUSCULOSKELETAL**
	Recent weight gain/loss: (circle one) how much:		Joint Pain
	BLOODBORNE PATHOGENS		Osteoporosis / Osteopenia
	Phlebitis		Bone/ Joint Infection
	HIV / AIDS		Gout
	Hepatitis		Rheumatoid Arthritis
	Hepatitis		**PSYCHOLOGICAL**
	NEUROLOGICAL		Depression
	Headaches		Anxiety Disorder
	Dizziness		**Other Illness not listed:**
	Fainting		
	Memory Loss		
	Loss of Consciousness		
	Muscle Spasms		
	Numbness or Tingling of Hands		
	Blindness or Trouble Seeing		
	Deafness or Trouble Hearing		
	Seizures		
FAMILY HISTORY			
	Diabetes		Anesthesia Complications
	Heart Disease		Cancer
SOCIAL HISTORY			
Occupation: Retired: yes no			
Martial Status: M S D W Race: Ethnicity:			
Smoker: Current: Yes No How much? Former: Yes No Quit Date:			
Do you drink Alcohol Yes No If so how many drinks per week? History of abuse? Yes No			
Any history of Drug Abuse? Yes No What Drug? Treatment?			

I acknowledge that these answers are accurate and complete to the best of my knowledge.

Patient Signature: ______________________________ Date: ______________________