Active
Orthopedics & Sports Medicine, LLC

MEDICAL INFORMATION SHEET

Patient Name:_____Age:_____ Date of Visit:_____

Present Complaint:_____

PRIMARY CARE PHYSICIAN'S NAME_____

PHONE_____

Please check any treatment that you have had for the current complaint:

☐ MRI ☐ CTSCAN ☐ THERAPY ☐ XRAYS ☐ SURGERY ☐ OTHER

How long have you been having this pain:_____How did this injury/pain begin:_____

Was it related to a motor vehicle or work related injury_____?

Past Medical History – Please check all that apply:

☐Asthma	☐ Sleep Apnea	☐ GERD
☐ Arthritis	☐ Blood Clots	☐ Osteoporosis
☐ Recurrent Infections	☐ Ulcers	☐ Gout
☐ Bleeding Disorder	☐ Stroke	☐ Thyroid Disease
☐ Cancer	☐ Diabetes	☐ High Cholesterol
☐ Heart Disease	☐ Circulation Problems	☐ HIV/Aids
☐ Kidney Disease	☐ Hypertension	☐ Other Communicable disease
☐ Other_____		☐ Prostate Disorder

Family History	**Mother**	**Father**
	☐No significant history	☐No significant history
Cancer	☐Yes ☐No	Cancer ☐Yes ☐No
Heart Disease	☐Yes ☐No	Heart Disease ☐Yes ☐No
Hypertension	☐Yes ☐No	Hypertension ☐Yes ☐No
Osteoarthritis	☐Yes ☐No	Osteoarthritis ☐Yes ☐No

Do you currently smoke? _____ **Have you ever smoked?_____**

Alcohol use? _____None _____Social ____Daily If so how much?_____

Do you have any allergies?

☐ Antibiotics/Medications_____	☐ Surgical Tape
☐ Iodine/Shellfish	☐ Local or general Anesthesia
☐ Seasonal allergies	☐ Other_____

CURRENT MEDICATIONS:_____

PAST SURGICAL HISTORY_____

Who referred you to our practice?

☐ Patient ☐Primary Care Physician ☐Another Physician ☐ Insurance Plan ☐Billboard/Advertisement

Patient's Signature_____