MOUNTAIN VALLEY ORTHOPEDICS, P.C

Patient Name: ____

Date of Birth:____________________________

*__Referring Physician__: ______________________________ **Primary Medical Doctor:** ________________________

Chief Complaint: ____

How did the injury occur?____ **Date of Onset or Injury:**_____________________

Pharmacy Name & Location: ____

To be completed by medical staff

HT:___________**WT:**______________**BP:**________________**Pulse:**______________**Resp:**________________

Are you allergic to LATEX? ☐ **Yes** ☐ **No**

DRUG ALLERGIES ☐ **Yes** ☐ **No** **if yes please list medication allergy, reaction and severity below:**

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

CURRENT MEDICATIONS & VITAMINS/Minerals: **Include name, dosage and directions.**

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

FAMILY HISTORY- Blood relatives with the following (Alive / Deceased PLEASE CIRCLE)

Family Member	Medical Problems
Mother: **Alive or Deceased**	☐ Diabetes (sugar) ☐ Hypertension ☐ Heart Problems ☐ Cancer ☐ Other: ___________________________
Father: **Alive or Deceased**	☐ Diabetes (sugar) ☐ Hypertension ☐ Heart Problems ☐ Cancer ☐ Other: ___________________________
Sisters: **Alive or Deceased**	☐ Diabetes (sugar) ☐ Hypertension ☐ Heart Problems ☐ Cancer ☐ Other: ___________________________
Brothers: **Alive or Deceased**	☐ Diabetes (sugar) ☐ Hypertension ☐ Heart Problems ☐ Cancer ☐ Other: ___________________________

Social History/Social Habits: **Check (✓) substances you have used.**

☐ Tobacco __ Current Smoker ___Previous Smoker ___ Non Smoker

☐ Alcohol – if yes, how often____

☐ Recreational Drugs/Steroid use? ____

☐ Occupation ___________________________________ ☐ **Left Handed** ☐ **Right Handed** ☐ **Ambidextrous**

SURGICAL HISTORY/HOSPITALIZATIONS:

YEAR	TYPE OF SURGERY/HOSPITALIZATION

MEDICAL HISTORY: Check (✓) if you have/had in the past ☐ **NOTHING BELOW APPLIES**

☐ HIV/ Aids
☐ Acid Reflux
☐ Anemia
☐ Anesthesia problems
☐ Angina
☐ Anxiety Disorder
☐ Depression
☐ Asthma
☐ Bleeding Disorder
☐ Blood Coagulation
☐ COPD
☐ Carpal Tunnel
☐ Chron's Disease
☐ DVT (Blood Clot)
☐ Diabetes (Type I or Type II)
☐ Fibromyalgia
☐ Food Allergies
☐ Frequent Infections
☐ Gout
☐ Hearing Loss
☐ Heart Attack (MI)
☐ Heart Disease
☐ Hepatitis
☐ High Cholesterol
☐ Hypertension
☐ Hyperthyroidism
☐ Immune System Disorder
☐ Kidney Disease
☐ Leg or Foot Ulcers
☐ Liver Disease
☐ Migraines
☐ Neurologic Disorder/Stroke
☐ Neuropathy
☐ Organ Transplant
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Peripheral Vascular Disease
☐ Pulmonary Embolism
☐ Reflux/GERD
☐ Seizures/Epilepsy
☐ Sleep Disorder
☐ Stomach Ulcers
☐ Thyroid Disease
☐ Tuberculosis

REVIEW OF SYSTEMS: **Check (✓) if you have or had in the past.** ☐ **NOTHING BELOW APPLIES**

CONSTITUTIONAL
☐Fever
☐Night sweats
☐Significant weight gain
☐Significant weight loss
☐Exercise Intolerance

EYES
☐Eye Problem

EARS
☐Difficulty hearing
☐Ear problems

NOSE
☐Frequent nosebleeds
☐Nose problems

MOUTH/THROAT
☐Sore throat
☐Bleeding gums
☐Oral ulcers
☐Teeth problems

CARDIOVASCULAR
☐Chest pain on exertion
☐Arm pain on exertion
☐Shortness of breath while walking
☐Shortness of breath while lying down
☐Palpitations
☐Known heart murmur

RESPIRATORY
☐Coughing
☐Wheezing
☐Shortness of breath
☐Coughing up of blood
☐Sleep apnea

GASTROINTESTINAL
☐Abdominal pain
☐Vomiting
☐Change in appetite
☐Black or tarry stool
☐Frequent diarrhea
☐Vomiting of blood
☐GERD

GENITOURINARY
☐Difficulty urinating
☐Increased urinary frequency
☐Hematuria (Blood in urine)
☐Incomplete emptying of bladder

MUSCULOSKELETAL
☐Muscle aches
☐Muscle weakness
☐Arthralgia/Joint pain
☐Back pain
☐Swelling in the extremities

INTEGUMENTARY (Skin)
☐Abnormal mole
☐Jaundice
☐Rash

NEUROLOGIC
☐Loss of consciousness
☐Weakness
☐Numbness
☐Seizures
☐Dizziness
☐Frequent or severe headaches
☐Migraines
☐Restless legs

PSYCHIATRIC
☐Depression
☐Sleep disturbances
☐Alcohol abuse

ENDOCRINE
☐Fatigue
☐Increased thirst
☐Hair loss
☐Increased hair growth
☐Cold intolerance

HEMATOLOGIC/LYMPHATIC
☐Swollen glands
☐Easy bruising
☐Excessive bleeding

IMMUNOLOGIC
☐Itching
☐Hives

Patient/Guardian Signature:____**Date:** ______________