SpecOrtho

Specialty Orthopaedics and Sports Medicine, LLC

DATE__________

Patient's Name: ________________________________ **Ref. Physician:** ___________________________

Date of Birth: _____/_____/_____ **Age**: _____ **Height**: _____ft. _____ inches **Weight:** ______ lbs.

Employment (Type): ____

Current Complaints: ____

____

Allergies/Difficulties with Medications & Reaction: None (_____) Latex (_____) Metal/Jewelry (_____)

Other: ____

Current Medications: **None** (_____) **Amount:**

____ __________________________________

____ __________________________________

____ __________________________________

____ __________________________________

____ __________________________________

Medical History (check all that apply):

_____Diabetes

_____Heart Disease

_____High Blood Pressure

_____Rhematoid Arthritis

Other ____

Other ____

Previous Surgeries: (____) None

*____ Date: ____________

*____ Date: ____________

*____ Date: ____________

*____ Date: ____________

*____ Date: ____________

Have you had any problems with Anesthesia? (_____) YES (_____) NO

***I certify that the above information is accurate and complete to the best of my knowledge. I will not hold SpecOrtho, its physicians or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form.**

Patient Signature: ________________________________

PATIENT MEDICAL HISTORY