

Orthopaedic Associates of Riverside

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Patient Name: _____

Date of Birth: _____

Age: _____

Occupation: _____

Height _____

Weight _____

Reason for today's visit: _____

Duration of symptoms: _____

Allergies: _____

Current Medications: _____

Alcohol Use: YES NO

Tobacco use: YES NO

Past Orthopaedic Problem(s): _____

Previous Surgery: _____

Family Medical History: _____

Have you ever had any of the following? (Please check all that apply)

- Heart Disease
- Pacemaker
- High Blood Pressure
- HIV/AIDS
- Circulatory Problems
- Hemophilia
- Artificial Heart Valves
- High Cholesterol
- Blood Clots/DVT
- Afib
- Epilepsy
- Stroke
- Nervous Problems
- Psychiatric Care
- Chemical Dependency
- Depression

- Sleep Apnea
- Neuropathy
- Respiratory Disease
- Asthma
- COPD
- Rheumatic Fever
- Recent Weight Loss
- GI Bleeding
- Acid Reflux
- Recurrent UTIs
- Chronic Diarrhea
- Hypothyroidism
- Kidney Disease
- Hepatitis
- Jaundice of Liver Disease

- Radiation Treatment
- Cancer
- MRSA
- Ulcer
- Gout
- Diabetes
- Rheumatoid Arthritis
- Back Problems
- Osteoarthritis
- Osteoporosis
- Joint Replacement
- Fibromyalgia
- Alcohol Abuse
- Drug Addiction

Signature of Patient or Guardian _____ Date _____