Orthopaedic Surgery Specialists, Ltd. – Adult Pre-Evaluation Form

Patient Name ______________________________ Age ________ Date of Birth _____ /_____ / ______

Occupation ____

Are you right or left handed? ___________________________

What is the reason for your visit today? ____

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____

When was the onset of your injury/problem? ____

How did this occur? (If applicable) ____

____

Have you had previous treatment for this injury/problem? (i.e. ER, Primary Care Physician) ____________

____

Are you currently taking any medications? If so, what are they and what are they for? ____________

____

Do you have any allergies to medications? If so, what are they and what is the reaction? ____________

____

Do you have any other medical problems? If so, what are they? _______________________________

____

Have you had any hospitalizations or injuries? If so, please list. _______________________________

____

Are you active in any sports/recreation activities? If so, please list. ___________________________

____

Do you smoke? Yes No Do you drink alcohol? Yes No Do you use recreational drugs? Yes No

Do you or anyone in your family have/had the following?

- ☐ Abdominal Pain
- ☐ Blood Clots/Stroke
- ☐ Blood Infections (Hepatitis, HIV)
- ☐ Bone Problems
- ☐ Bowel or Bladder Problems
- ☐ Cancer
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Difficulty with Anesthesia
- ☐ Headaches
- ☐ Heart Disease
- ☐ Nerve Problems
- ☐ Vision Problems

Is there any other significant family medical history the doctor should be aware of? ________________

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*If you have any other pertinent information that you would like to share with the doctor, please use the backside of this form.

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