

WOODFIELD ORTHOPAEDICS & SPORTS MEDICINE, LTD

DATE __/__/____

NAME _____ HEIGHT _____ WEIGHT _____ AGE _____

1. DATE OF INJURY OR WHEN DID PROBLEM START? _____

2. CURRENT PROBLEM _____

3. HOW DID IT START? _____

4. HAVE YOU SEEN ANOTHER PHYSICIAN? __Y __N WHO? _____

5. HAVE YOU BEEN OFF WORK? __Y __N IF SO SINCE WHEN? _____

6. DO YOU HAVE ANY MEDICAL CONDITIONS INVOLVING:

KIDNEY __Y __N

HEART __Y __N

LUNG __Y __N

STOMACH/INTESTINE __Y __N

DIABETES __Y __N

NEUROLOGICAL __Y __N

7. ARE YOU OR COULD YOU BE PREGNANT? __Y __N

8. SURGERIES INCLUDING DATES _____

9. CURRENT MEDICATIONS/DOSAGES _____

10. ALLERGIES _____

11. DO YOU? SMOKE __Y __N

DRINK __Y __N

USE RECREATIONAL DRUGS __Y __N

12. FAMILY PHYSICIAN _____ PHONE# _____ FAX# _____

ADDRESS _____

Street

City

State

Zip

SIGNATURE _____