MIDWEST ORTHOPAEDIC CONSULTANTS, S.C.

(Please Complete)

Name:____ Age :_________ Date:__________

Occupation:____ Height:_________ Weight:________

Name of the referring physician?_________________________________

Why were you referred here?___________________________________

Area affected (e.g. right hand, left hand, left knee) ____________________ Hand Dominance R___ L___

Date of injury?_______________ Type of injury: auto___ work___other______________________________

How long have you had this present condition?____

Is this injury or condition work related? Yes_____________ No_______________

Have you been treated for this condition before? Yes___ No___ If yes, list treatment so far:

____

____

Do you have these diseases?

YES	NO		YES	NO	
____	____	Asthma or Emphysema	____	____	Stroke
____	____	Diabetes	____	____	Bleeding Problem
____	____	Thyroid Disease	____	____	Heart Problem
____	____	High Blood Pressure	____	____	Kidney Problem
____	____	Liver Problem (jaundice, hepatitis)	____	____	Stomach Ulcer
____	____	Respiratory Disease	____	____	Seizure Disorder
____	____	Family History of Anesthesia Problems	____	____	Cancer
____	____	Family History of Bleeding Problems	____	____	Pacemaker

Please list all the **medications** you are taking:

Medications	Dosage	Frequency
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

Are you **allergic** to any medications? Yes___ No___ If yes, what: ______________________________

Do you **smoke**? Yes___ No___

Do you drink excessive **alcohol**? Yes___ No___

Please list any Surgeries:____

____

Patient's Signature:____ Date:____________________