

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

\_\_\_ \_\_\_ Asthma or Emphysema

\_\_\_ \_\_\_ Diabetes

\_\_\_ \_\_\_ Thyroid Disease

\_\_\_ \_\_\_ High Blood Pressure

\_\_\_ \_\_\_ Liver Problem (jaundice, hepatitis)

\_\_\_ \_\_\_ Respiratory Disease

\_\_\_ \_\_\_ Family History of Anesthesia Problems

\_\_\_ \_\_\_ Family History of Bleeding Problems

YES NO

\_\_\_ \_\_\_ Stroke

\_\_\_ \_\_\_ Bleeding Problem

\_\_\_ \_\_\_ Heart Problem

\_\_\_ \_\_\_ Kidney Problem

\_\_\_ \_\_\_ Stomach Ulcer

\_\_\_ \_\_\_ Seizure Disorder

\_\_\_ \_\_\_ Cancer

\_\_\_ \_\_\_ 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: \_\_\_\_\_