ORTHOPAEDIC ASSOCIATES OF READING, LTD.

PATIENT INFORMATION:

Today's Date:____________________

Patient Name: ____ Date of Birth:____________________

Referring Physician: ____

Primary Care Physician:____

Patient's Height: _________________ Patient's Weight:____________________

Home Address:____

Home Phone: (______) _________ - __________ Work Phone: (______) ________ - ___________

Significant Other Name:_____________________________________ Significant Other DOB:____________

IN CASE OF EMERGENCY, CONTACT:

Name: ____

Relationship: ____

Home Phone: (______) _________ - __________ Work Phone: (______) ________ - ___________

MEDICAL HISTORY:

Check (✓) you have or have had in the past.

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
  Type:_________________
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ DVT / PE
- ☐ Pacemaker/ICD
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Prostate Disease
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Gastric Ulcers
- ☐ Other
  ____
  ____

ORTHOPAEDIC HISTORY:

What body part is being assessed today? ____

Have you had any previous Orthopaedic treatment on this body part? YES ☐ NO ☐

Have you had any previous Orthopaedic surgery on this body part? YES ☐ NO ☐

If yes, name of Orthopaedic surgeon: ____

Date(s) of surgery: ____

Type of procedure(s): ____

MEDICATION:

Are you currently taking any blood thinners? YES ☐ NO ☐

If yes, please list the blood thinner(s) that you are currently taking:_____________________________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any of his/her staff responsible for any errors or omissions that I may have made in completion of this form

Signature ____ Date _________________