



Name: _____

Age: _____ Height: _____ Weight: _____

Please list any ALLERGIES you may have to any drugs, latex, tape, etc.

Please list all medications you are currently taking, including vitamins:

<u>Medication</u>	<u>Dosage</u>	<u>Times Per Day</u>	<u>Reason for taking</u>

Please check any and all of the following medical conditions that apply to you:

- | | | |
|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Angina / Chest Pain | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Prosthetic Heart Valve | <input type="checkbox"/> Pacemaker / Defibrillator |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sleep Apnea / CPAP Use | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Under Active Thyroid | <input type="checkbox"/> Hyper Active Thyroid | <input type="checkbox"/> Hepatitis / Liver Disorder |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Anemia / Bleeding Disorder | <input type="checkbox"/> Hemophilia / Clotting Disorder | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Neurologic Disorder | <input type="checkbox"/> Muscle Disorder | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Chronic Constipation | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers |

Please provide details of all above checked items:

Please list all previous surgeries and dates:

Please indicate any complications you or a blood relative may have had with Anesthesia previously:

Do you use any assistive devices, i.e. wheelchair, crutches, walker?

Social History

Do you currently smoke? Yes No If yes approximately how many packs per day? _____

Are you a former smoker? Yes No How long ago did you quit and how much did you smoke? _____

Do you drink alcohol? Yes No If yes, amount per day? _____

Work Status:

Full Time Part Time Student Retired Disabled

Occupation: _____

Off Work Restricted Duty Full Duty

Family History

Family Member

High Blood Pressure _____
 Diabetes _____
 Heart Disease _____
 Bleeding Disorder _____
 Cancer (type) _____

About your current condition:

Reason for today's visit and how long have symptoms been present:

Any known injury, if so when and where?

What course of treatment have you had for this condition, (i.e. x-ray, therapy, medication), by who and when?

Any additional information relevant to your condition:

Pharmacy Name: _____

Location: _____

Phone Number: _____

By signing this form you are agreeing that the information above is true and accurate to the best of your knowledge and you are granting Skyview Orthopedic Associates permission of treatment.

Signature

Relationship

Date

WHERE EVERY PATIENT COUNTS!

