advocare | Orthopedic and Sports Medicine Center

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:

Medication	**Dosage**	**Times Per Day**	**Reason for taking**

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

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