

Orthopaedic Surgery Specialists, Ltd. - Adult Pre-Evaluation Form

Patient Name _____ Age _____ Date of Birth ____ / ____ / ____

Occupation _____

Are you right or left handed? _____

What is the reason for your visit today? _____

When was the onset of your injury/problem? _____

How did this occur? (If applicable) _____

Have you had previous treatment for this injury/problem? (i.e. ER, Primary Care Physician) _____

Are you currently taking any medications? If so, what are they and what are they for? _____

Do you have any allergies to medications? If so, what are they and what is the reaction? _____

Do you have any other medical problems? If so, what are they? _____

Have you had any hospitalizations or injuries? If so, please list. _____

Are you active in any sports/recreation activities? If so, please list. _____

Do you smoke? Yes No Do you drink alcohol? Yes No Do you use recreational drugs? Yes No

Do you or anyone in your family have/had the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Blood Clots/Stroke | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nerve Problems |
| <input type="checkbox"/> Blood Infections (Hepatitis, HIV) | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Bone Problems | <input type="checkbox"/> Difficulty with Anesthesia | |
| <input type="checkbox"/> Bowel or Bladder Problems | <input type="checkbox"/> Headaches | |

Is there any other significant family medical history the doctor should be aware of? _____

*If you have any other pertinent information that you would like to share with the doctor, please use the backside of this form.