

PERSONAL INFORMATION

Name: _____ Age: _____ Right Left Handed Male Female
Height _____ Weight _____ Email Address: _____
Who sent you to see Dr. Miller? _____ Relationship to you? _____
Referring/Primary Care Physician: _____

Chief Complaint: _____

Date of Accident/Onset: _____ / _____ / _____

Please describe the recent events that brought on this orthopaedic problem: _____

How long has it been a problem? _____

What makes it worse? _____ What makes it better? _____

MEDICAL HISTORY

Please check all that apply

- Heart Disease High Blood Pressure Lung Disease Diabetes Thyroid Disorder Depression Back Pain
 Ulcer or Stomach Disease Kidney Disease Liver Disease Anemia or other blood disease Cancer
 Osteoarthritis, degenerative arthritis Rheumatoid Arthritis Other medical condition: _____

PAST SURGICAL HISTORY

TYPE OF SURGERY

DATE

WHERE

NAME OF SURGEON

- | | | | |
|----------|--------------------|-------|-------|
| 1. _____ | ____ / ____ / ____ | _____ | _____ |
| 2. _____ | ____ / ____ / ____ | _____ | _____ |
| 3. _____ | ____ / ____ / ____ | _____ | _____ |
| 4. _____ | ____ / ____ / ____ | _____ | _____ |
| 5. _____ | ____ / ____ / ____ | _____ | _____ |
| 6. _____ | ____ / ____ / ____ | _____ | _____ |

MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		

ALLERGIES

ALLERGY	REACTION
1.	
2.	
3.	

SOCIAL HISTORY

Martial Status: Married Single (never married) Divorced/Seperated Widowed
Living with significant other

Employer: _____ Job Title: _____ Student Homemaker Retired

Hobbies/ Recreational Activities: _____

Do you smoke? Yes No If yes how many packs per day? _____ How long? _____