BONE & JOINT SPECIALISTS

LITTLE COMPANY OF MARY MEDICAL GROUP

Patient Name: _____

Patient Date of Birth: ____-____-_____

Today's Date: ____-____-_____

Please complete the information below.

Please list any prescription or over the counter medications you are currently taking with the dosage and frequency.

_____
_____
_____
_____

Please list any long term medical problems that you have been diagnosed with.

_____
_____
_____
_____

Please list any drug, food, or seasonal allergies you may have.

_____
_____

Please list any previous surgeries you have had.

_____
_____
_____

Please select one of the following:

- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Divorced

Do you have any children?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

Please list your occupation:

_____

Do you consume alcohol?

- ☐ Never
- ☐ Former
- ☐ Current
- ☐ How many drinks per day? _____

Do you smoke?

- ☐ Never
- ☐ Former
- ☐ Current
- ☐ How much per day? _____

Do you use smokeless tobacco?

- ☐ Never
- ☐ Former
- ☐ Current
- ☐ How much per day? ____

Please list your Primary Care Doctor: _____

Please list your referring Doctor: _____

Please list what type of insurance you have: _____

Date of symptom onset: _____

Have you been seen by an Orthopedic Doctor before? If so, please list who and what was treated:

_____

_____

Please circle the area(s) that you would like to be addressed at today's visit: