



Orthopaedic Center of Mesquite

Name _____ Today's Date _____

SS # _____ Date of Birth _____ Age _____

Referring MD or Person _____ Send Report? Yes No

Family MD _____ Send Report? Yes No

What orthopedic problem are you seeing the doctor today for? _____

Current problem is the result of a(n): *(check all that apply)*

Car Accident _____ Work Accident _____ Accident _____ Other _____

Date of Accident _____ Describe _____

Job Title _____ Hand Dominance _____

Present Work Status: Working _____ Not Working _____ Light Duty _____

Past Medical History *(List any prior and current illnesses & injuries, such as high blood pressure, diabetes, heart problems, cancer, etc.)*

Prior Surgery and Hospitalizations *(Describe the surgery or procedure, state the year, and describe any complications)*

Have you ever had general anesthesia? No Yes

Have you ever had any problems with anesthesia? No Yes Describe _____

Please list medications you are taking at the present time, and the dosage, below:

Medication	Dose	Medication	Dose
ALLERGIES			

BLOODPRESSURE: _____ PULSE: _____ WEIGHT: _____ LBS: _____ HEIGHT: _____