ARMSTRONG ORTHOPEDIC ASSOCIATES

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77 Glade Drive
Kittanning, PA 16201

PATIENT INFORMATION & MEDICAL HISTORY

PATIENT FULL NAME: _____

PARENT OR GUARDIAN (if patient is a minor): _____

PATIENT ADDRESS: _____

_____

HOME PHONE: _____ CELL / WORK PHONE:_____

DATE OF BIRTH: _____ AGE:_____ SEX: MALE FEMALE

HEIGHT: _____ WEIGHT: _____

NAME OF SPOUSE: _____ MARITAL STATUS:_____

SOCIAL SECURITY NO: _____

PATIENT / PARENT EMPLOYER: _____

EMPLOYER ADDRESS & PHONE: _____

EMERGENCY CONTACT NAME & PHONE: _____

FAMILY PHYSICIAN & PRACTICE LOCATION: _____

OTHER PHYSICIANS WHO TREATED YOU: _____

WERE YOU REFERRED TO OUR PRACTICE? YES NO BY WHOM? _____

REASON FOR TODAY'S VISIT: _____

HAVE YOU HAD RECENT XRAYS: YES NO IF YES, WHERE? _____

OCCUPATION & JOB DUTIES: _____

PAST OR PRESENT MEDICAL ISSUES THAT YOU HAVE BEEN TREATED FOR:

_____

_____

LIST ALL PREVIOUS SURGERIES: _____

_____

ANY KNOWN ALLERGIES: _____
DO YOU HAVE A METAL ALLERGY? YES NO

LIST ALL CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATIONS:

_____

ADDITIONAL HISTORY – PLEASE CHECK YES OR NO. (PLEASE DO NOT LEAVE ANY BLANK)

□ YES □NO CHILLS/FEVER
□ YES □NO WEIGHT CHANGE LOSS or GAIN (CIRCLE ONE)
□ YES □NO HEADACHES
□ YES □NO DIZZINESS
□ YES □NO EPILEPSY/CONVULSIONS
□ YES □NO PARALYSIS
□ YES □NO EYE PROBLEMS
□ YES □NO PHLEBITIS/DVT/BLOOD CLOTS
□ YES □NO CANCER TYPE_____
□ YES □NO SHORTNESS OF BREATH
□ YES □NO ASTHMA
□ YES □NO EMPHYSEMA
□ YES □NO PNEUMONIA
□ YES □NO ARTHRITIS
□ YES □NO STROKE
□ YES □NO HARDENING OF ARTERIES/PVD
□ YES □NO JOINT PAIN
□ YES □NO FAINTING
□ YES □NO RHEUMATIC FEVER
□ YES □NO HEART PROBLEMS TYPE_____
□ YES □NO GALLBLADDER
□ YES □NO NAUSEA
□ YES □NO LIVER PROBLEMS TYPE_____
□ YES □NO APPETITE CHANGES
□ YES □NO HEARTBURN
□ YES □NO ULCER WHEN_____
□ YES □NO BOWEL PROBLEMS TYPE_____
□ YES □NO PROSTATE PROBLEMS
□ YES □NO URINARY PROBLEMS TYPE_____
□ YES □NO DIABETES HOW LONG_____
□ YES □NO VENEREAL DISEASE
□ YES □NO BLEEDING DISORDERS
□ YES □NO PACEMAKER

HOW MUCH CAFFEINE DO YOU CONSUME IN ONE DAY? _____
CIRCLE ALL THAT APPLY: COFFEE TEA SODA POP

DO YOU USE TOBACCO PRODUCTS? YES NO
CIRCLE ALL THAT APPLY: CIGARETTES CIGARS CHEWING TOBACCO
HOW MUCH PER DAY? _____ FOR HOW LONG? _____

DOES ANYONE IN YOUR HOUSEHOLD SMOKE? YES NO
IF YES, WHO AND HOW MUCH? _____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO
HOW MUCH PER DAY? _____ TYPE OF BEVERAGE: _____

SOCIAL OR INTRAVENOUS DRUG USE? PAST PRESENT NEVER

DO YOU HAVE A HIGH STRESS LEVEL? YES NO
WHY? _____

HAVE YOU EVER BEEN ENROLLED IN PAIN MANAGEMENT? _____

****FAMILY MEDICAL HISTORY****

ANY KNOWN DISEASES THAT RUN IN YOUR FAMILY? _____
MOTHER: _____
FATHER: _____
BROTHERS/SISTERS: _____

ARE YOUR PARENTS LIVING?
MOTHER: YES NO
FATHER: YES NO

IF NOT, CAUSE(S) OF DEATH: _____

****<u>FEMALE</u> SPECIFIC HISTORY****

ARE YOU OR IS IT POSSIBLE THAT YOU MAY BE PREGNANT? YES NO

DO YOU TAKE A CALCIUM SUPPLEMENT? YES NO

HAVE YOU BEEN DIAGNOSED WITH OSTEOPOROSIS? YES NO