

Orthopaedic Associates of Saratoga

5 Care Lane • Saratoga Springs, New York 12866

Tel: 518/587-0845 Fax: 518/587-5068

www.orthosaratoga.com

MEDICAL HISTORY

What is the Main Problem that brings you here? _____

What has been done for it so far (x-rays, treatment): _____

Have you had your Bone Density tested? Yes: _____ No: _____

Is this injury related to work? Yes: _____ No: _____ (please notify receptionist if yes)

Is this injury related to a motor vehicle accident? Yes: _____ No: _____

Date of Accident or Injury _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

- | | |
|--|--|
| <input type="checkbox"/> Lung Problems / Asthma | <input type="checkbox"/> Date of Last Pap Smear |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Chronic Cough / TB | <input type="checkbox"/> Seizures / Convulsions |
| <input type="checkbox"/> Heart Attack / Angina / Murmur | <input type="checkbox"/> Visual Disturbance (Glaucoma / Cataracts) |
| <input type="checkbox"/> Night-Time Shortness of Breath | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke / Paralysis |
| <input type="checkbox"/> Swelling in Hands / Feet / Legs | <input type="checkbox"/> Numbness in Hands / Feet / Legs |
| <input type="checkbox"/> Abdominal Pain / Ulcers | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Changes in Bowel / Bladder Habits | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia or Bleeding Problems |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer |

Medications (How much, how often, why?) _____

Allergies to Medications (What happens?) _____

Do you have or have you ever had an allergic reaction to latex? _____ What happened? _____

Previous Surgeries: _____

Complications from Surgeries / Anesthesia: _____

What Tobacco/Alcohol do you use daily: _____

Age: _____ Height: _____ Weight: _____ Right Handed: _____ Left Handed: _____

Family History of Cancer: _____ Heart Disease: _____ Other: _____

Family Physician: _____ Address: _____

Would you like him/her to be sent a report? Yes _____ No _____

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other health plan to *Orthopaedic Associates of Saratoga*. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Liability cases are the patient's responsibility. I will meet the customary payment schedules. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____