



Advanced Orthopedic & Sports Medicine Institute, LLC



620 NW Eleventh Street, Suite 201 • Hermiston, Oregon 97838 • Ph. (541) 289-7075

Name: _____ Date of Birth: _____
 Age: _____ Height: _____ Weight: _____ B/P _____ M.I. _____ Pulse _____ Temp _____

REASON FOR VISIT

REFERRING PHYSICIAN

FAMILY HISTORY

List any blood relative that has had or died from any of the following (include age) check ALL that apply:

- Cancer _____ Diabetes _____ Epilepsy _____
 Heart disease _____ High blood pressure _____ Blood diseases _____
 Congenital problems _____ Aneurysms _____ Brain tumors _____
 Stroke _____ Problems with anesthesia _____ Other _____

PAST MEDICAL HISTORY Do you now or have you ever had? (Check if "yes")

<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> GERD	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Kidney failure
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pulmonary embolus	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumor (benign)	<input type="checkbox"/> Tumor (malignant)	<input type="checkbox"/> Other

SOCIAL HISTORY

Occupation: _____ Present employer: _____

Married Single Retired Living Independently Number of children: _____

Do you drink alcohol? No Yes, type and number of drinks/week _____

Do you smoke? No Yes, packs per day _____ years smoked _____ Past, quit when? _____

Do you use drugs for reasons that are not medical? No Yes, please list: _____

Hobbies/Avocation: _____

PAST SURGICAL HISTORY

	Type of Surgery	Year	Reason for Surgery
1.			
2.			
3.			
4.			
5.			



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Have you ever had a blood transfusion? Yes, what year? _____ No
 Are you pregnant? Yes No

PRESENT MEDICATIONS Yes No (list including aspirin, laxatives, vitamins, herbs, and other supplements :)

Drug Name	Dose(mg)	Frequency(times per day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

DRUG ALLERGIES Yes, please list No:

Drug Name	Reaction (rash, difficulty breathing, anaphylaxis, etc.)
1.	
2.	
3.	
4.	

SYSTEMS REVIEW Please check ALL which have significantly affected you and explain:

<input type="checkbox"/> Weight loss	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Seizures
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Fevers	<input type="checkbox"/> Constipation	<input type="checkbox"/> Headaches
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Weakness
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Numbness
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Kidney infections	<input type="checkbox"/> Vision loss
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Double vision
<input type="checkbox"/> Swelling of feet/ankles	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Impotence	<input type="checkbox"/> Depression
<input type="checkbox"/> Rashes, sores	<input type="checkbox"/> Balance difficulty	<input type="checkbox"/> Anxiety

Reviewed by: _____ Date: _____