

ORANGETOWN ORTHOPEDIC ASSOCIATES
99 Dutch Hill Road, Orangeburg, New York 10962

ACCT# _____ NAME _____ AGE _____ DATE _____

PLEASE INDICATE IF YOU HAVE HAD OR STILL HAVE ANY OF THE FOLLOWING (circle as necessary):

	YES	NO		YES	NO
STOMACH PAIN / BLEEDING ULCER / GASTRITIS / IRRITABLE BOWEL SYNDROME			OSTEOARTHRITIS – where?		
			RHEUMATOID ARTHRITIS		
HEPATITIS/LIVER TROUBLE			LUPUS / SCLERODERMA/ LYME DISEASE		
DIABETES / HIGH BLOOD SUGAR			IMMUNE DISORDER		
LOW BLOOD SUGAR			BACK PAIN OR BACK INJURY NECK / UPPER BACK / LOWER BACK		
HEART DISEASE CHEST PAIN CORONARY ARTERY DISEASE HEART ATTACK IRREGULAR HEART BEAT MURMUR LEAKING VALVE			LUNG DISEASE EMPHYSEMA/ CHRONIC BRONCHITIS COPD ASTHMA PNEUMONIA		
			THYROID TROUBLE		
HIGH BLOOD PRESSURE			BLOOD CLOT: (DVT / PULMONARY EMBOLUS)		
LOW BLOOD PRESSURE					
STROKE			BLEEDING TENDENCY/ EASILY BRUISE		
CANCER (now or in past) Type?			SICKLE CELL DISEASE / TRAIT		
			ANEMIA		
RHEUMATIC FEVER			PRIOR BLOOD TRANSFUSIONS?		
TUBERCULOSIS			SEIZURE DISORDER / EPILEPSY		
RECENT ILLNESS? Cough			How Much do you smoke?		Pks/ day
Fever			How much alcohol do you drink?		Drink /day
Chills			Latex Allergy?		
Significant weight loss			Do you use a cane or walker ?		
Night sweats					
Hemoptysis – coughing up blood					

PRIOR SURGERY _____

REACTIONS TO ANESTHESIA BY YOU OR FAMILY MEMBER _____

ALLERGIES _____

LIST CURRENT MEDICATION _____

I HAVE RECEIVED THE PRIVACY NOTICE AND I DO NOT HAVE ANY QUESTIONS

PATIENT SIGNATURE _____

DOCTOR SIGNATURE _____