Rapides Orthopedic Clinic

Patient Name: ______________________________

Medical Information Sheet

Who Is Your Primary Care Physician:

Have You Seen Any Other Physician For This Problem? ( ) Yes ( ) No If So, Who?

Are You Left Or Right-Handed? | If Female, Could You Possibly Be Pregnant?

Are you currently receiving Physical, Occupational, or Speech Therapy? ( ) Yes ( ) No
If so, when did you begin?

Are you currently receiving Home Health Services? ( ) Yes ( ) No If so, which agency?

Previous Surgical Procedures

~ Please List ~

Current Medications

Medication Name	Dosage	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medication Allergies:

Do you Smoke? ( ) Yes ( ) No If Yes, how many packs per day? How many years?

Do you Drink Alcohol? ( ) Yes ( ) No If Yes, how often?

Do you have any of the following Problems:

( ) Heart Problems	( ) Emphysema	( ) Kidney Problems
( ) High Blood Pressure	( ) Tuberculosis	( ) Liver Problems (Hepatitis)
( ) Stroke	( ) Circulation Problems	( ) Arthritis
( ) Blood Clots	( ) Diabetes	( ) Gout
( ) Anemia	( ) Hearing Difficulty	( ) Thyroid Problems
( ) Bleeding Problems	( ) Implants	( ) Psychiatric Treatment
( ) Cancer	( ) Ulcers	( ) Depression
( ) Asthma	( ) Bladder Infections	( ) Neurological Problems (Epilepsy)
( ) Bad Teeth	( ) Digestive Problems	( ) Other

Reviewed by: ______________________________, **M.D.** **Date:** ____________________