ATLANTA ORTHOPAEDIC SPECIALISTS
PATIENT HISTORIES

NAME: ____

Birth Date: ____________________ Date of Injury: ____________________

Primary Complaint or Problem: ______________________________________

Reason for Visit:

___Consult ___Worker's Comp. ___MVA ___Sports Injury ___Other Injury ___Insurance

Currently working: ___Yes ___No _______________Date last worked

Have you ever had or do you presently have any of the following conditions? (Check all that apply):

___Heart Disease	___HIV	___Gout
___Stomach Ulcer	___Thyroid Disease	___Inflammatory Arthritis
___Kidney Disease	___High Blood Pressure	___Active or Recurring Infections
___Hepatitis	___Diabetes	___Psoriasis
___Bleeding Disorder	___Phlebitis	___Crohns/Ulcerative Colitis
___Anemia	___Cancer	___Asthma
___Depression/Anxiety Disorder		___Seizures

Please list all previous surgeries: ______________________________________

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Please list all present medications: ______________________________________

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Please list all known drug allergies: ______________________________________

Please list any medical conditions common in your family: ______________________

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Do you smoke? ___________ How much per day? ____________________

Do you drink? ___________ How much per day? ____________________

To the best of my knowledge, the information above is accurate and complete.

X______________________________________ Date: _______________