

**THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI  
NEW PATIENT MEDICAL INFORMATION SHEET  
(PLEASE ANSWER ALL QUESTIONS ON BOTH SIDES)**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

CIRCLE ONE: MR. MRS. MS. DR. RIGHT-HANDED LEFT-HANDED

WHAT BRINGS YOU TO SEE THE DOCTOR TODAY? \_\_\_\_\_

WHICH SIDE IS BOTHERING YOU? (CIRCLE ONE) RIGHT LEFT BOTH

IS THIS DUE TO AN INJURY? YES NO DATE OF INJURY: \_\_\_\_\_

HOW DID INJURY OCCUR? \_\_\_\_\_

IS THIS A WORK RELATED INJURY? YES NO

IS THERE A LAWSUIT OR LAWYER INVOLVED? \_\_\_\_\_

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_

FAMILY PHYSICIAN'S NAME: \_\_\_\_\_

**PAST MEDICAL HISTORY**

**ARE YOU ALLERGIC TO ANY MEDICATIONS OR OTHER ITEMS?**

(PLEASE LIST THEM AND WHAT OCCURS WHEN TAKEN)

Reaction \_\_\_\_\_

Reaction \_\_\_\_\_

**WHAT MEDICATIONS DO YOU TAKE?**

\_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST ANY SURGERIES YOU HAVE HAD:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ILLNESSES: (Have you ever had or now have any of the following?)**

Diabetes Mellitus	Yes	No	Arthritis (type)	Yes	No
High Blood Pressure	Yes	No	Lung Disease	Yes	No
Heart Problems	Yes	No	Asthma	Yes	No
Stroke	Yes	No	AIDS or HIV	Yes	No
Hepatitis	Yes	No	Cancer (type)	Yes	No
Reflux (Heart Burn)	Yes	No	Bleeding Problems	Yes	No
Alcoholism	Yes	No	Blood Clots	Yes	No
Gout	Yes	No	Thyroid Disease	Yes	No
Kidney Problems	Yes	No	Depression	Yes	No
Neurologic Problems	Yes	No			
Other _____					

**DO YOU PRESENTLY SMOKE CIGARETTES, CIGARS OR A PIPE? Yes No**  
**IF YES, HOW MANY PACKS A DAY AND FOR HOW LONG? \_\_\_\_\_**

**DO YOU DRINK ALCOHOL? Yes No**  
**(AVERAGE NUMBER OF DRINK IN A WEEK) \_\_\_\_\_**

**OCCUPATION? \_\_\_\_\_**  
**PLACE OF EMPLOYMENT \_\_\_\_\_**

**HAS ANYONE IN YOUR FAMILY EVER HAD:**

<b>High Blood Pressure _____</b>	<b>Diabetes _____</b>
<b>Heart Disease _____</b>	<b>Lung Disease _____</b>
<b>Cancer (type) _____</b>	<b>Tuberculosis _____</b>
<b>Bleeding Problems _____</b>	<b>Anesthesia Complications _____</b>

**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING RECENTLY?**  
**(LAST 3 TO 4 WEEKS)**

<b>Chest Pain</b>	<b>Yes</b>	<b>No</b>
<b>Shortness of Breath</b>	<b>Yes</b>	<b>No</b>
<b>Fever</b>	<b>Yes</b>	<b>No</b>
<b>Weight Loss</b>	<b>Yes</b>	<b>No</b>
<b>Recent Infection (location)</b>	<b>Yes</b>	<b>No</b>
<b>Burning or Stinging on Urination</b>	<b>Yes</b>	<b>No</b>

**PATIENT SIGNATURE \_\_\_\_\_**

**PHYSICAL EXAMINATION**

**HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_**