THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI

NEW PATIENT MEDICAL INFORMATION FORM

(PLEASE ANSWER ALL QUESTIONS)

PATIENT'S NAME: _____ **AGE:** _____ **TODAY'S DATE** _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

WHICH SIDE IS BOTHERING YOU? (circle one) **LEFT** **RIGHT** **BOTH**

HOW DID INJURY OCCUR? _____

IS THIS A WORK RELATED INJURY? **YES** **NO**

IF YOU ANSWERED YES TO THE PREVIOUS QUESTION, DID YOU FILE A CLAIM WITH YOUR EMPLOYER? **YES** **NO**

IS THERE A LAWSUIT OR LAWYER INVOLVED? **YES** **NO**

PRIMARY CARE PHYSICIAN'S NAME: _____

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE?

_____

_____

_____

_____

PLEASE LIST ALL ALLERGIES

_____

_____

_____

_____

PLEASE LIST ALL SURGERIES YOU HAVE HAD

_____

_____

_____

_____

WHAT TYPE OF WORK DO YOU DO? _____

WHO IS YOUR EMPLOYER? _____