PREMIER ORTHOPEDICS, PC

PREMIER #_____

Name: _____ **Today's Date:** _____

Date of Birth_____ **Age**_____ **Height**_____ **Weight**_____

Check the location of your problem today:

☐ Lower Back	☐ Left Arm	☐ Left Shoulder	☐ Left Hip	☐ Right Arm	☐ Right Shoulder	☐ Right Hip
☐ Upper Back	☐ Left Elbow	☐ Left Knee	☐ Left Ankle	☐ Right Elbow	☐ Right Knee	☐ Right Ankle
☐ Neck	☐ Left Hand	☐ Left Leg	☐ Left Foot	☐ Right Hand	☐ Right Leg	☐ Right Foot

HOW DID IT HAPPEN?

Is this visit due to an injury? ☐ Yes ☐ No Workers' Compensation Claim? ☐ Yes ☐ No Motor Vehicle Accident? ☐ Yes ☐ No

Date of Injury_____ How did the injury occur? (please be detailed)_____

_____

ALLERGIES

List all allergies (or provide a list): _____

REVIEW OF SYSTEMS (ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING)

Constitutional Systems

Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Lack of appetite	☐ Yes	☐ No

Eyes

Blurred vision	☐ Yes	☐ No
Crossed eyes	☐ Yes	☐ No
Eye Pain	☐ Yes	☐ No
Discharge	☐ Yes	☐ No

Ears / Nose / Mouth / Throat

Difficulty swallowing	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Earache	☐ Yes	☐ No
Post-nasal drip	☐ Yes	☐ No

Cardiovascular

Chest pain	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Abnormal blood pressure	☐ Yes	☐ No
Swellilng of ankles/legs	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Chest pain with exertion	☐ Yes	☐ No

Respiratory

Asthma	☐ Yes	☐ No
Dry Cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Gastrointestinal

Bloating	☐ Yes	☐ No
Change in bowel habits	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Stomach pain	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No

Genitourinary

Hematuria	☐ Yes	☐ No
Excessive/reduced urination	☐ Yes	☐ No
Kidney/bladder infections	☐ Yes	☐ No

Musculoskeletal

Arthritis	☐ Yes	☐ No
Joint pain/ache/stiffness	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Muscle pain	☐ Yes	☐ No
Weakness, "hot joint"	☐ Yes	☐ No

Integumentary (Skin)

Hives	☐ Yes	☐ No
Redness	☐ Yes	☐ No
Lumps	☐ Yes	☐ No
Wounds	☐ Yes	☐ No
Rashes	☐ Yes	☐ No
Change in nail/hair texture	☐ Yes	☐ No
Bruising	☐ Yes	☐ No

Neurological

Blackouts	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Loss of balance	☐ Yes	☐ No
Loss of coordination	☐ Yes	☐ No
Loss of sensation	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

Psychiatric

Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Forgetfulness	☐ Yes	☐ No
Loss of sleep	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No

Endocrine

Diabetes	☐ Yes	☐ No
Hot flashes	☐ Yes	☐ No
Low Sugar	☐ Yes	☐ No
Thyroid condition	☐ Yes	☐ No
Excessive hunger/thirst	☐ Yes	☐ No

Hematologic/Lymphatic

Swollen glands/nodes	☐ Yes	☐ No
Nosebleed	☐ Yes	☐ No
Bruising	☐ Yes	☐ No

Allergic/Immunologic

Allergies	☐ Yes	☐ No
Autoimmune disorder	☐ Yes	☐ No

Name: _____ **Today's Date:** _____ **Premier #**_____

CURRENT MEDICATIONS

List all medications you are currently taking (or provide a list):
:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Your Pharmacy Name_____

Street Address_____ City_____ State_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Employed: ☐ Yes ☐ No

Living Situation: ☐ Alone ☐ Spouse or Family ☐ Friends Disabled: ☐ Yes ☐ No

Student: ☐ Yes ☐ No School_____

Tobacco Usage: ☐ Yes ☐ No Alcoholic Beverages: ☐ Yes ☐ No

PAST MEDICAL HISTORY

Have ***you*** ever had any of the following:

Diabetes	☐ Yes ☐ No	Blockage of blood vessels: neck	☐ Yes ☐ No	Diverticulitis	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Blockage of blood vessels: legs	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Asthma / Emphysema	☐ Yes ☐ No	Hepatitis A, B, or C	☐ Yes ☐ No
Blackouts / Seizures	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No	Gout	☐ Yes ☐ No
Dizzy Spells / Vertigo	☐ Yes ☐ No	Fractures / Dislocations	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Frequent Kidney Infections	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Irregular Heart Rate	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Kidney Failure	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Heart Failure	☐ Yes ☐ No	Frequent Heartburn	☐ Yes ☐ No	Psoriasis	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Stomach Ulcer	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	Gall Bladder Disease	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Stroke / CVA	☐ Yes ☐ No	Pancreatitis	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
TIA's	☐ Yes ☐ No	Ulcerative Colitis / Crohn's Disease	☐ Yes ☐ No		

Has a ***family member*** ever had any of the following:

Diabetes	☐ Yes ☐ No	Blockage of blood vessels: neck	☐ Yes ☐ No	Diverticulitis	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Blockage of blood vessels: legs	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Asthma / Emphysema	☐ Yes ☐ No	Hepatitis A, B, or C	☐ Yes ☐ No
Blackouts / Seizures	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No	Gout	☐ Yes ☐ No
Dizzy Spells / Vertigo	☐ Yes ☐ No	Fractures / Dislocations	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Frequent Kidney Infections	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Irregular Heart Rate	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Kidney Failure	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Heart Failure	☐ Yes ☐ No	Frequent Heartburn	☐ Yes ☐ No	Psoriasis	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Stomach Ulcer	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	Gall Bladder Disease	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Stroke / CVA	☐ Yes ☐ No	Pancreatitis	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
TIA's	☐ Yes ☐ No	Ulcerative Colitis / Crohn's Disease	☐ Yes ☐ No		

List any other medical history you think is important for us to know:_____

_____

PAST SURGICAL HISTORY

List *ALL* previous surgeries and year:

_____ _____ _____

_____ _____ _____

Signature of Patient or Responsible Party if Patient is Under the Age of 18: _____