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Knee & Shoulder Specialists

Board Certified Orthopedic Surgeons
Sports Medicine Specialists

Patient Name _____ Date Of Birth ____/____/____ Age _____

Height _____ Weight _____ Right or Left Handed _____

General Questions

Reason for consultation? _____

When did your symptoms first occur? _____

Who is your primary care physician? _____

Who referred you to this office? _____

Have you seen any other doctors for this problem? _____

Have you had any X-Rays, MRI, or testing done? _____

If so, when and where were they done? _____

List any surgeries you have had and when. _____

Have you had any reactions to anesthetic? _____

Do you take aspirin or blood thinners? _____

Is there a chance you could be pregnant? _____

Do you smoke? _____ If so, how much? _____ Do you drink? _____ If so, how much? _____

Medications (Provide List If Available)

Medication	Dosage	Frequency

Do you have any allergies to medications? _____

Social/Family History

Are your parents living? _____ If not, cause of death? _____

Are your siblings living? _____ If not, cause of death? _____

List any history of cancer in your family. Who? _____ What Type? _____

Serious Medical Conditions in Relatives. _____

See reverse side...