NEW WEST ORTHOPAEDIC & SPORTS REHABILITATION, LLC
Medical History

NAME: ____AGE:______DOB:___________ Male/Female_______________

OCCUPATION:____HEIGHT:_______________WEIGHT:_______________

FAMILY PHYSICIAN:______________________________________REFERRED BY:___________________________________

PLEASE DESCRIBE THE PROBLEM YOU ARE BEING SEEN FOR TODAY:____
____

IS THIS PROBLEM WORK RELATED?_____________________________ WHEN DID PROBLEM BEGIN?_________________

HAVE YOU HAD ANY OTHER THERAPY FOR THIS PROBLEM?____

PLEASE LIST **ALL MEDICATIONS** THAT YOU ARE CURRENTLY TAKING:
____________________________ __________________________ _____________________________ ______________________

____________________________ __________________________ _____________________________ ______________________

LIST **ALL ALLERGIES:** ____

ARE YOU ALLERGIC TO LATEX? YES_______NO _______

LIST ALL PAST SURGERIES (DATES IF KNOWN):
____________________________ __________________________ _____________________________ ______________________

____________________________ __________________________ _____________________________ ______________________

HAVE YOU HAD OR DO YOU PRESENTLY SUFFER FROM:

Anemia	Yes__No__	Hepatitis	Yes__No__
Angina, Heart Problem, Pacemaker	Yes__No__	Tuberculosis	Yes__No__
Arthritis	Yes__No__	Blood Transfusion	Yes__No__
Asthma	Yes__No__	Ulcer/Stomach Bleeding/Indigestion	Yes__No__
Cancer/Tumor	Yes__No__	Thyroid Disorder	Yes__No__
Diabetes	Yes__No__	Depression or Anxiety	Yes__No__
Emphysema/Chronic Bronchitis	Yes__No__	Chemical Dependency/Alcoholism	Yes__No__
Hearing Loss	Yes__No__	Blood Clots/Phlebitis	Yes__No__
Heart Valve Problems	Yes__No__	Bleeding Disorder Tendency	Yes__No__
High Blood Pressure	Yes__No__	Difficulty Voiding	Yes__No__
Irregular Heartbeat	Yes__No__	Kidney Bladder Infection	Yes__No__
Night Sweats/Weight Gain/Loss	Yes__No__	Reaction to General/Local Anesthesia	Yes__No__
Osteoporosis	Yes__No__	Psoriasis/Skin Rash	Yes__No__
Seizures/Stroke	Yes__No__	Elevated Cholesterol	Yes__No__
Vision loss or Glaucoma	Yes__No__	Pneumonia	Yes__No__

List Any Other Medical Problems Not Mentioned Above: ____

Have you had Cortisone? Yes______No_______ Injections or Pills?____

Tobacco Use? Yes______No ______ How Often?_________ Caffeine Use?Yes______No ______ How Often?__________

List any additional information that you feel would be important to your treatment: ____________________________
____

Signature:____ **Date:**_____________________________