

New Patient Information

Blake Ohlson, M.D., Orthopaedics

Name: _____ Date: _____

Age: _____ DOB: _____ Sex: *Male* *Female*

Family MD: _____ Date of onset of injury/problem: _____

Did a doctor refer you to our office? *YES NO* If yes, list his/her name, address and phone #:

_____ Phone: _____

Are you working now? *YES NO* What is your occupation? _____

Please describe your current orthopaedic problem/ injury: _____

Is your problem/injury related to: *(please check)*

____ Auto-accident ____ Work-related accident ____ Other accident ____ Litigation pending

MEDICATIONS: *(Please list all known long-term medications, including current medications, over-the-counter drugs and herbal preparations):*

Are you currently taking Coumadin or other blood thinning medications? *YES NO*

ADVERSE AND ALLERGIC DRUG REACTIONS: *(please check)*

____ None ____ Penicillin ____ Sulfa Drugs ____ Other, please list:

Reaction: _____

PAST MEDICAL HISTORY:

Have you ever or do you currently have any of the following? Please check all that apply:

- | | | | |
|----------------------------------|---------------------------|-----------------|--------------------|
| ____ High Blood Pressure | ____ Cataracts | ____ Stroke | ____ Blood Clots |
| ____ Thyroid Disorder | ____ Asthma | ____ MRSA | ____ Sleep Apnea |
| ____ Congestive Heart Failure | ____ Diabetes | ____ Pneumonia | ____ Lyme Disease |
| ____ Fibromyalgia | ____ Gout | ____ Seizure | ____ Latex Allergy |
| ____ High Cholesterol | ____ Polio | ____ Depression | ____ Anxiety |
| ____ Heart Attack/ Mi Disorder | ____ GI | ____ Kidney | ____ Stomach Ulcer |
| ____ Hepatitis/Liver Disorder | ____ Tuberculosis | | |
| ____ Seizure Disorder / Epilepsy | ____ Rheumatoid Arthritis | | |

Please list any other medical problems: _____

PAST MEDICAL HISTORY:

Known Significant Operative and Invasive Procedures: *(type of procedure and dates)*

Have you ever had a problem with any of the following types of anesthesia? *(please check)*

___ General ___ IV Sedation ___ Local ___ Dental Anesthesia

If you checked any of the above types of anesthesia, please explain the problem:

FAMILY HISTORY: *(check any family illnesses)*

___ Diabetes ___ Bleeding problems ___ Anesthesia Problems ___ Other *(describe below):*

SOCIAL HISTORY:

___ Single ___ Married ___ Widowed ___ Live Alone ___ Live With Others

Do you smoke tobacco? YES NO How much? _____ # of years? _____

Do you drink alcohol? YES NO How much? _____

History of substance abuse? YES NO If yes, please describe _____

Are you or could you be pregnant? YES NO

KNOWN SIGNIFICANT MEDICAL DIAGNOSES AND CONDITIONS:

Height: _____ Weight: _____

Please circle and describe the symptoms that pertain to you:

YES NO Constitutional *(fever, weight loss, etc.):* _____

YES NO Heart *(chest pain, murmur, irregular beats, etc.):* _____

YES NO Circulation *(high blood pressure):* _____

YES NO Respiratory *(asthma, shortness of breath, cough, etc.):* _____

YES NO Gastrointestinal (GI) *(appetite, diarrhea, constipation, etc.):* _____

YES NO Urinary *(problems urinating, incontinence, etc.):* _____

YES NO Musculoskeletal *(arthritis, stiffness, etc.):* _____

YES NO Skin *(acne, rash, etc.):* _____

YES NO Neurological *(seizures, weakness, balance, etc.):* _____

YES NO Psychiatric *(depression, mood liability, other):* _____

YES NO Endocrine *(thyroid problem):* _____

YES NO Hematologic *(bleeding tendency, anemia):* _____

OTHER: Are there other questions or concerns that you have for your Doctor today? If so, please list them below: