

URQUHART ORTHOPEDIC ASSOCIATES, P.A.

MARC W. URQUHART, M.D., FACS

ERICA ROWE URQUHART, M.D., Ph.D.

DEBBIE HAGER, PA-C

NAME: _____
 SS #: _____

TODAYS DATE: ___/___/___
 DATE OF BIRTH: ___/___/___

CHIEF COMPLAINT

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

CURRENT PROBLEM IS RESULT OF A(N): CHECK ALL THAT APPLY

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> CAR ACCIDENT | <input type="checkbox"/> WORK ACCIDENT |
| <input type="checkbox"/> ACCIDENT | <input type="checkbox"/> OTHER |

MEDICATION	DOSE	REASON FOR MEDICATION	SIDE EFFECTS

ALLERGIES _____

ARE ALL IMMUNIZATIONS UP TO DATE? YES NO
 IF NO, WHICH IMMUNIZATIONS ARE DUE? _____

TETANUS YES NO DATE RECEIVED ___/___/___

REVIEW OF SYSTEMS

ARE YOU CURRENTLY HAVING OR HAVE YOU HAD PROBLEMS WITH YOUR: _____
 DESCRIBE ALL YES RESPONSES

- | | | | | | |
|------------------------|--------------------------|-----|--------------------------|----|-------|
| EYES | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| EARS, NOSE, THROAT | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| LUNGS, BREATHING | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| DIGESTION | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| BOWEL MOVEMENT | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| BLADDER PROBLEM | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| DIABETES | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| HIGH BLOOD PRESSURE | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| BLEEDING PROBLEMS | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| BALANCE PROBLEMS | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| NUMBNESS/TINGLING | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| BLACKOUT/FAINTING | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| PSYCHOLOGICAL PROBLEMS | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| AIDS | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| CANCER | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| ARTHRITIS | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| POLIO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| TB | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |
| EPILEPSY | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | _____ |

PATIENT SIGNATURE: _____ DATE: _____
 REVIEWED BY: _____ MD DATE: _____

NAME _____

PAST MEDICAL HISTORY

SURGERIES/HOSPITALIZATIONS	YEAR	COMPLICATIONS

HAVE YOU EVER HAD GENERAL ANESTHESIA? YES NO DESCRIBE _____
 DO YOU HAVE ANY PROBLEMS WITH ANESTHESIA? YES NO _____

FAMILY HISTORY

MEMBER	ALIVE	DECEASED	AGE	HEALTH STATUS OR CAUSE OF DEATH
GRANDMOTHER(MOM)	<input type="checkbox"/>	<input type="checkbox"/>		
GRANDFATHER(MOM)	<input type="checkbox"/>	<input type="checkbox"/>		
GRANDMOTHER(DAD)	<input type="checkbox"/>	<input type="checkbox"/>		
GRANDFATHER(DAD)	<input type="checkbox"/>	<input type="checkbox"/>		
FATHER	<input type="checkbox"/>	<input type="checkbox"/>		
MOTHER	<input type="checkbox"/>	<input type="checkbox"/>		
SISTER/BROTHER	<input type="checkbox"/>	<input type="checkbox"/>		
SISTER/BROTHER	<input type="checkbox"/>	<input type="checkbox"/>		
SISTER/BROTHER	<input type="checkbox"/>	<input type="checkbox"/>		
SISTER/BROTHER	<input type="checkbox"/>	<input type="checkbox"/>		

SOCIAL HISTORY

WORK IN THE HOME EMPLOYED(OCCUPATION _____)
 STUDENT DAYCARE RETIRED
 SINGLE MARRIED DIVORCED SEPARATED WIDOWED
 CHILDREN? NO YES # _____
 DO YOU LIVE ALONE? NO YES _____
 EXERCISE? DAILY WEEKLY MONTHLY RARELY NEVER
 WHAT TYPE OF EXERCISE? _____
 HISTORY OF SUBSTANCE ABUSE? NO YES WHAT? _____
 SMOKE CURRENTLY? NO YES _____ PACKS PER DAY FOR _____ YEARS.
 QUIT SMOKING? THIS YEAR >1 YEAR >5 YEARS >10 YEARS
 PREVIOUSLY SMOKED _____ PACKS PER DAY FOR _____ YEARS.
 DRINK ALCOHOL? DAILY 1-2 x/WEEK 1-2 x/MONTH 1-2 x/YEAR

PATIENT SIGNATURE: _____ DATE: _____
 REVIEWED BY: _____ MD DATE: _____