



## MEDICAL INFORMATION

Are you allergic to any medication?  Yes  No. If yes, explain: \_\_\_\_\_

Are you taking any medication? If yes, please list with dosage and how often: \_\_\_\_\_

Do you smoke:  Yes  No. If yes, number of packs per day \_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcohol?  Yes  No. If yes, how much per week? \_\_\_\_\_

What orthopaedic problem would you like checked (please indicate right or left side)?

\_\_\_\_\_

Was this an injury?  Yes  No. If yes, Date of injury \_\_\_\_\_

How did the injury occur: \_\_\_\_\_

Is there a lawyer involved in your medical problem?  Yes  No. If yes, please give name: \_\_\_\_\_

Is this a work related problem?  Yes  No. If yes, please complete the following: Date of injury: \_\_\_\_\_ Who were you working for at the time of the injury?

What was your job? \_\_\_\_\_

What does that involve you doing? \_\_\_\_\_

\_\_\_\_\_

What is your work status now? \_\_\_\_\_

Please list the name of any other doctor(s) you have seen for this condition: \_\_\_\_\_

\_\_\_\_\_

If there was no injury, how long have you had this problem? \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you  Right handed  Left handed  Ambidextrous

Please list any non-surgical treatments you have had for the main orthopaedic problem: (e.g. medications, physical therapy, etc...) \_\_\_\_\_

Have you had any surgical procedures for this problem?  Yes  No. If yes, explain what and when: \_\_\_\_\_

\_\_\_\_\_

Previous surgery(s) not mentioned above: \_\_\_\_\_

\_\_\_\_\_

Are you participating in any organized sports?  Yes  No. Identify sport(s)

Name of School or League: \_\_\_\_\_ Coach or trainers names: \_\_\_\_\_

\_\_\_\_\_