



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: _____
