

Capital City Orthopaedics and Sports Medicine

Today's Date _____ Name _____ Age _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Phone _____
Height _____ Weight _____

Present Condition

Type of Injury

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Non-specific injury (problem developed over time) |
| <input type="checkbox"/> | <input type="checkbox"/> | Injury due to employment?

(Worker's Compensation Claim #) |
| <input type="checkbox"/> | <input type="checkbox"/> | Injury due to auto accident?

(Responsible Insurance Company) |
| <input type="checkbox"/> | <input type="checkbox"/> | Specific injury occurrence: _____
(Date of Injury) |

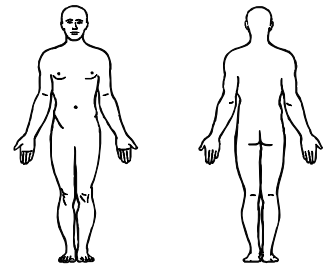
Describe Problem

Identify Problem Area(s)

- Left
 Right

Put mark on problem area(s)

- Injury occurred at:
- | | |
|--|-------|
| <input type="checkbox"/> Home | _____ |
| <input type="checkbox"/> Place of Work | _____ |
| <input type="checkbox"/> Sports Activity | _____ |
| <input type="checkbox"/> Other: _____ | _____ |



Please give us as many details as possible, i.e., was this injury due to a fall? Did it happen while working out? Lifting a child?

Past Medical History

Regular Physical Activity/Exercise: _____

Surgery: Give Date and Physician _____

Hospitalizations with Dates: _____

Serious Illnesses:

Ulcers	Yes	No	Liver Disease	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No
Heart Disease	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Other _____		

Fractures: _____

Present Medications: List Name and Daily Dosage

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

*Allergies to Medications: Describe Reaction

Females Only: Pregnant At Present? Yes No