Wabash General Hospital

Orthopaedic Surgery & Sports Medicine

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(PLEASE PRINT & COMPLETE IN FULL)

Patient's Last Name: _____ First Name: _____ M.I. _____
Date of Birth: _____ Age: _____ Sex: _____ Social Security #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ @ _____

(Check the following that applies to the patient)
Marital Status: ___ Single ___Married ___Divorced ___Widowed ___ Partner
Employed: ___ Full Time ___ Part Time ___Retired ___ Unemployed
Student: ___ Full Time ___Part Time ___ Not a Student
Smoker Status: ___Smoker ___ Former Smoker ___ Not a Smoker

Patient Employer: _____ Occupation: _____
Employer Phone#: _____ Ext. _____
Employer Address, City, State, Zip: _____

Spouse or Parent Name (circle one):_____DOB: _____ S.S. # _____
Spouse or Parent Employer: _____ Work Phone: _____

Family Physician: _____ Phone #: _____
Referring Physician: _____ Phone#: _____
Cardiologist (if applicable): _____ Phone#: _____
Dentist: _____ Phone#: _____
Pharmacy: _____ Phone #: _____

Please list who we may speak with regarding your medical information: _____

In the event that a parent/legal guardian cannot accompany this patient to a future appointment, please indicate who can and their relationship to the patient: _____

May we leave messages at the telephone numbers you have listed? ___Yes ___No
Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone #: _____

(Please notify receptionist if the insurance to be billed is a worker's compensation claim, motor vehicle accident, or personal injury claim.)

HEALTH INSURANCE INFORMATION

Patient relationship to subscriber: ___ Self ___Spouse ___Child ___Other(explain if other): _____
*** Primary Insurance: _____** Policy #: _____
Policy Holder Name: _____ Policyholder DOB: _____ S.S. # _____
Insured's Employer (if different than above): _____
Employer Phone #: _____
*** Secondary Insurance: _____** Policy #: _____
Policy Holder Name: _____ Policyholder DOB: _____ S.S. # _____
Insured's Employer (if different than above): _____
Employer Phone #: _____
Patient Name: _____ Date of Birth: _____

Illnesses: (Please circle **YES** or **NO** if you have any of the following medical problems)

High Blood Pressure	Y	N	Diabetes	Y	N	Heart Trouble	Y	N
Respiratory Problems	Y	N	Stroke	Y	N	Cancer	Y	N
Bleeding Problems	Y	N	HIV/AIDS	Y	N	COPD	Y	N
Pulmonary Embolism	Y	N	Blood Clot	Y	N	Depression	Y	N
Gastrointestinal Problems	Y	N	Anemia	Y	N	Fibromyalgia	Y	N
Gallbladder disease	Y	N	Gout	Y	N	GERD	Y	N
Hepatitis	Y	N	Scoliosis	Y	N	Thyroid disease	Y	N
Seizure disorder	Y	N	Kidney disease	Y	N	Liver disease	Y	N
Migraines	Y	N	Other Problems: _____					

Past hospitalizations/surgeries/injuries and approximate dates: _____

_____

_____

Allergies: (Please circle those that apply) **None**

Contrast Dye Sulfa Penicillin Local Anesthetics Latex Iodine Shellfish

Other: _____

Current Medications: (Please use back of this paper if you need more room) **None**

Medication Name	Dosage	Frequency

Family History: (Please list any family history of medical problems: i.e. heart disease, stroke, diabetes, cancer)

_____

_____

Social History: (Please circle all those that apply)

Tobacco use:	Never	Packs per day:	Years of use:	Quit/When:
Alcohol use:	Never	Rarely	Moderate	Daily Amount:
Drug use:	Never	Type and frequency:		

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Right Handed: _____ Left Handed: _____

*** REASON FOR SEEING DOCTOR/SYMPTOMS _____ DATE OF INJURY/ONSET: _____**

Was injury or onset related to: **Work:** Y N **Auto Accident:** Y N **Other** (school, sports, activity, etc. explain…):

_____

_____

How did the injury/problem occur? _____

_____

Any previous treatment or problems? (include any medications prescribed) _____

_____

History of present illness:

Location of your pain: **(please specify right or left)** _____

_____

Severity of your pain: (please circle one **0(least)** and **10(worst)**

1 2 3 4 5 6 7 8 9 10

Character of the pain: (dull, sharp, achy, throbbing, shooting, etc.) _____

_____

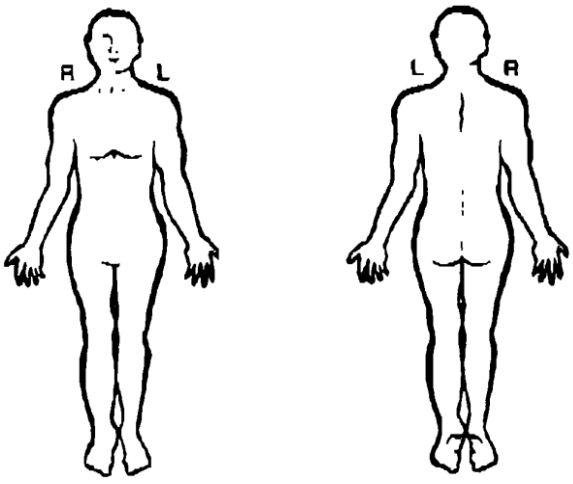
Is there a time of day or certain activity that makes the pain worse? Is the pain constant? _____

_____

Associated symptoms: (swelling. Locking, giving out, etc.) _____

_____

Pain Drawing: Place X's at the location of your worst pain using the diagram below:



Patient Signature (parent/guardian/legal representative): _____ Date: _____

Physician Signature: _____ Date: _____