PATIENT INFORMATION

Is today's visit for? ☐ First Visit ☐ Established Patient ☐ Pre-Op/Post-Op ☐ Other

Full Name: _____ Preferred Name: _____

Social Security Number: _____-_____-_____ Sex: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Martial Status: _____ Race: _____ Language: _____

PATIENT or GUARANTOR EMPLOYER INFORMATION

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐Other

Employer: _____ Job Title: _____

Address: _____ Phone: _____

EMERGENCY CONTACT / HIPAA AUTHORIZATION

In the event of an emergency, please contact the person listed below. If left blank, Modern Orthopedics will assume you do not want us to contact anyone in the event of an emergency.
Check the box next to the names of those who you wish to authorize to obtain your personal medical information. If left unchecked, Modern Orthopedics will assume you do not want us to release your medical information to anyone.

Name:	DOB:	Relationship:	Phone:	HIPAA?
				☐
				☐
				☐
				☐

CURRENT OR PAST MEDICAL CONDITIONS:

- ☐ Asthma
- ☐ Hypertension
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Stroke
- ☐ COPD
- ☐ Sleep Apnea/CPAP
- ☐ Hepatitis
- ☐ Crohn's
- ☐ Reflux/Heartburn
- ☐ Gout
- ☐ Cardiovascular Disease
- ☐ Thyroid Disease
- ☐ Kidney Problems
- ☐ Stomach Ulcers
- ☐ Colitis
- ☐ MRSA
- ☐ Parkinsons
- ☐ Dementia
- ☐ HIV/AIDS
- ☐ Osteoporesis
- ☐ Blood Clotting Disorder
- ☐ Liver Problems
- ☐ Cancer
- ☐ Blood Thinners
- ☐ Pulmonary Embolus
- ☐ Psychiatric Illness
- ☐ Depression
- ☐ Anxiety
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Chronic Steroids

☐ Other:

SURGICAL HISTORY:

Eyes/ENT
- ☐ Cataracts
- ☐ Vision Correction
- ☐ Sleep Apnea
- ☐ Tonsils
- ☐ Sinus Surgery
- ☐ Thyroid

Heart/Lung
- ☐ Bypass/CABG
- ☐ Valve Replacement
- ☐ Stents
- ☐ Lungs Resection

Gastrointestinal
- ☐ Appendix
- ☐ Gallbladder
- ☐ Hernia

Gynecologic
- ☐ C-section
- ☐ Hysterectomy
- ☐ Tubal Ligation

Urologic
- ☐ Prostate
- ☐ Bladder
- ☐ Vasectomy

Orthopedic
- ☐ Joint Replacement
- ☐ Arthroscopy
- ☐ Fracture surgery
- ☐ Spine

Vascular
- ☐ Carotid
- ☐ Aneursym
- ☐ Bypass

Cancer
- ☐ Skin
- ☐ Breast
- ☐ Thyroid

☐ Other:

MODERN ORTHOPEDICS

New Patient Medical History Form

INNOVATIVE ORTHOPAEDIC SOLUTIONS

SOCIAL HISTORY:

- ☐ **None of these**
- ☐ Alcohol
- ☐ Smoking/Vaping
- ☐ Chewing Tobacco/Dip
- ☐ Marijuana

FAMILY HISTORY:

- ☐ **None of these**
- ☐ Anesthesia Complications
- ☐ Blood Clots
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease

Anesthesia Complications:

- ☐ None
- ☐ Yes (explain):

_____

_____

Complications after prior surgery:

- ☐ Infection
- ☐ Blood Clot
- ☐ Bleeding
- ☐ Anesthesia Complications:

_____

- ☐ Other:

_____

ALLERGIES: ☐ NO ALLERGIES

- ☐ Penicillin
- ☐ Sulfa
- ☐ Nickel
- ☐ Metals
- ☐ Latex
- ☐ Iodine (contrast)
- ☐ Shellfish
- ☐ NSAIDs
- ☐ Tape/Adhesive
- ☐ Other: _____

MEDICATIONS:

MEDICATIONS (please list ALL)	DOSE (mg, pill, etc)	TIMES PER DAY