FONDREN ORTHOPEDIC GROUP L.L.P.

Name:____ Date: ______________________

Age:_______Weight:______Height:______ DOB: ________ Who Referred You? ______________________

MEDICAL HISTORY: PLEASE ANSWER ALL QUESTIONS-ENTER N/A IF NOT APPLICABLE

Please check any of the following medical conditions that you have or have had in the past:

____Diabetes	____Bleeding Disorders	____HIV	____Allergy to Aspirin/NSAID
____Tuberculosis	____Thyroid Problems	____Hepatitis	____Gout/Chondrocalcinosis
____Abnormal EKG	____Kidney Disease	____Asthma	____Connective Tissue Disorder
____Chest Pain (Angina)	____Liver Dysfunction	____Infections	____Peptic Ulcer Disease
____Heart Disease	____Current Pregnancy	____Cancer	____Difficulty with Anesthesia
____Cardiac Arrhythmia	____ Mitral Valve Prolapse	____Jaundice	____Abnormal Chest X-ray
____Heart Murmur	____Hypertension/High Blood Pressure	____Obesity	____Osteoporosis

*List any significant medical family history: ____

*List past surgeries: ____

*Social History: Use of Alcohol? **YES NO** If YES-how much? _____________
Use of Tobacco? **YES NO** If YES-how much and how long? _________________
Use of Recreational or nonprescription drugs? **YES NO**

*Current Medications: ____

*Allergies to Medicine: ____

*Are you under a physicians care? **YES NO** If YES-Name & Phone#:_____________________________

*What will we be treating you for today?____

*Was this an injury? **YES NO** If YES-Date of Injury: __________Where did injury occur?________________

I hereby grant permission to the physicians of Fondren Orthopedic Group LLP to perform such medical treatment they deem necessary. I understand that I am responsible for disclosing any changes in the above answers that I have provided at all times. I understand that I will need to complete a similar form when treatment consists of a medical problem other than the problem listed above or to update the form on file.

Signature:____Date:_________________________

Office Use Only: Patient Account# ______________________Reviewed By:____________________________________