

Lebanon Orthopaedic Associates

Medical Information Sheet

Today's Date _____

Date of Birth _____

Name _____

Age _____

Height _____

Weight _____

Referring Dr. _____

Family Dr. _____

Employer _____

Problem / Body area to be treated? [Please circle left or right if applicable] _____

Physician Comments: _____

Is this a work related injury? No _____ Yes _____ Date _____
Is this a car accident injury? No _____ Yes _____ Date _____
Is this another type of accident injury? No _____ Yes _____ Date _____
Did you have X-rays taken? No _____ Yes _____ Where _____

PAST MEDICAL HISTORY

Have you ever been treated for any of the following? Please check.

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Depression / Anxiety |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Abdominal Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Urination Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Infections | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fractures | If known: Type _____ |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Swollen Glands | |

List all operations you have had: _____

Physician Comments: _____

