MCNEIL ORTHOPEDICS, INC.

Name: _____ Today's Date: _____

Birth date: ___/___/___ Age: _____ Gender: M ❑ F ❑ Left ❑ or Right ❑ Handed?

Height: _____ ft _____ inches Weight: _____ lbs Date of Injury _____

Reason for visit: _____ Are you Pregnant? Y ❑ N ❑

Have you had X-rays for this problem? Y ❑ N ❑ If yes, where were they done? _____

Is this a Worker's Comp Injury? Y ❑ N ❑ Auto Accident Injury? Y ❑ N ❑ Is this a legal case? Y ❑ N ❑

"This ENTIRE form should be COMPLETELY filled out!"

USE OF TOBACCO: ❑ Smoke every day ❑ Some days ❑ Quit ❑ Never Smoked

MARITAL STATUS: ❑ Married ❑ Single ❑ Widow ❑ Other

EMPLOYMENT: ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled ❑ Student

USE OF ALCOHOL: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily

Drinks per day ____ Use of any other recreational drugs not listed above? _____

Cancer: ❑ Yes ❑ No _____

Other medical problems: _____

Fractures/broken bones you have had? _____

List all your prior SURGERIES:

❑ Appendectomy	❑ Ankle Surgery
❑ Cholecystectomy	❑ Knee Replacement
❑ Hernia	❑ Knee Arthroscopy
❑ Cardiac Bypass	❑ Shoulder Arthroscopy
❑ Pacemaker	❑ Vascular Surgery
❑ Fracture Treatment	❑ Breast Surgery
❑ Hip Replacement	❑ Cancer Surgery
❑ Hysterectomy	❑ Gallbladder Surgery
❑ Vein Ligation	❑ Carpal Tunnel Surgery
❑ Cataract	❑ Elbow Surgery
❑ ACL	❑ Back/Spine Surgery
❑ Tonsillectomy	❑ No Past Surgery

Other Surgeries: _____

List all MEDICATIONS you currently take:

MEDICATION	MEDICATION

Preferred Pharmacy & Location: _____

Drug Allergies: _____

DO YOU HAVE ANY PREVIOUS HISTORY OF DVT/BLOOD CLOTS? _____

DO YOU HAVE ANY PREVIOUS HISTORY OF STENTS? _____

Please indicate (☒) current and/or past conditions YOU *have* had

❑ Abnormal Bleeding	❑ Epilepsy/Seizures	❑ Phlebitis/Blood Clot
❑ Anemia	❑ Fibromyalgia	❑ Pneumonia
❑ Anxiety	❑ Frequent Heartburn/Reflux Disorder	❑ Osteoarthritis
❑ Arthritis	❑ Gout	❑ Polio
❑ Asthma	❑ Heart Attack	❑ Rheumatic Fever
❑ Back/Neck Pain or Injury	❑ Heart Murmur	❑ Rheumatoid Arthritis
❑ Bleeding Problems	❑ Hepatitis	❑ Scoliosis
❑ Chest Pain	❑ High Blood Pressure	❑ Shortness of Breath
❑ Crohn's/Colitis	❑ Hypertension	❑ Stroke/Paralysis
❑ Depression	❑ Kidney Disease	❑ Thyroid Disease
❑ Diabetes	❑ Liver Disease	❑ Tuberculosis
❑ Elevated Cholesterol	❑ Pacemaker/Defibrillator	❑ Ulcers
❑ Emphysema	❑ Degenerative Disc Disease	❑ No Significant Medical History
❑ AIDS/HIV Positive	❑ Peripheral Vascular Disease	

Please indicate (☒) major medical problems that your FAMILY MEMBERS (alive or deceased) have had:

❑ Arthritis	❑ Hypertension	❑ Heart Disease
❑ Stroke	❑ Gout	❑ Neurological Disorders
❑ Osteoporosis	❑ Depression	❑ Migraines
❑ Cancer	❑ Blood Clots	❑ High Blood Pressure
❑ Liver Disease	❑ Bleeding Disorders	❑ Elevated Cholesterol
❑ Kidney Disease	❑ Diabetes	❑ No Significant Family History
❑ Pulmonary Embolism	❑ Thyroid Disease	

Other Family History: _____

Patient's Signature: _____ Date: _____

Reviewed by: _____ Date: _____