

ORTHOPEDECS OF N SCOTTSDALE  
 10250 N 92ND STREET STE 114  
 SCOTTSDALE AZ 85258 480/661-8348

Patient Name:  
 Date:

**NEW PATIENT MEDICAL INFORMATION FORM**

Please answer the following questions as best you can. Estimate dates, ages, or answers for those not recalled accurately.  
 What is your reason for seeing the doctor?

**Past Medical History (Please circle)**

Anxiety    Alcoholism    Autoimmune Disorder    Asthma    Cancer  
 Cholesterol problems    Depression    Diabetes    High Blood pressure    Heart Attack  
 Heart troubles    Lung Problems    Stroke

Other: \_\_\_\_\_

Past Surgeries:

**Medications:**

Name of medication    Dose    Frequency taken

Allergies or Adverse effects to medication:    No    Yes-please list

**Family History: (full blooded relatives)**

	YES	NO	YES	NO
Anesthesia problems			Lung disease	
Arthritis		Migraines	Muscle weakness	
Back/Neck problems			Neuro. disorders	
Cancer			Seizures	
Cardiac			Psych history	
Gastro intestinal			Thyroid disease	
Hepatitis			Transfusion reaction	
Kidney/bladder			Smoker	
Liver disorder				

**Social History:**

What is (or was) your Occupation?

Marital Status:    Married    Divorced    Never married    Widowed    Significant Other

Do you smoke?    No    Yes

Did you quit smoking in the past?    No    Yes

Do you drink alcoholic beverages?    NO    YES    SOMETIMES