WESTERN ORTHOPAEDICS
Excellence in Motion
1830 Franklin Street, Suite 450
Denver, CO 80218

Patient Information Form

Please complete all information

PATIENT NAME _____

Preferred method of contact

❑ phone (_____) _____ – _____

❑ text message (_____) _____ – _____

❑ e-mail address _____

Disease History: Do you have or have you had any of the following?

LUNG

- ❑ Bronchitis
- ❑ Emphysema
- ❑ Asthma
- ❑ TB
- ❑ Sinusitis
- ❑ Respiratory Infections
- ❑ Sleep Apnea
- ❑ Smoker
  - Packs per Day _____
  - # of Years _____
- ❑ Former Smoker
  - Year Quit _____

VASCULAR

- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Circulatory Problem
- ❑ Heart Disease
- ❑ Sickle Cell
- ❑ Stroke

SYSTEMIC

- ❑ Muscle/Nerve Disease
- ❑ Diabetes
- ❑ Glandular Trouble
- ❑ Hepatitis: ❑ Type A ❑ Type B ❑ Type C
- ❑ Kidney/Bladder Problems
- ❑ Alcohol Use Y / N
  - Amount _____
- ❑ Stomach/Bowel Problem
- ❑ Polio
- ❑ Back/Disc Disease
- ❑ Jaundice
- ❑ Convulsions
- ❑ Headaches
- ❑ Fainting
- ❑ Glaucoma
- ❑ Malignant Hyperthermia (High Fever)
- ❑ HIV Virus/AIDS

Drug History: In the last six months have you taken any of the following drugs?

- ❑ Steroids
- ❑ Birth Control Pills
- ❑ Antibiotics
- ❑ Asthma Medication
- ❑ Anti-Coagulants (blood thinners)
- ❑ Aspirin
- ❑ Arthritis Medication
- ❑ Tranquilizers
- ❑ Narcotics
- ❑ Other _____
- ❑ Insulin or diabetic
- ❑ Thyroid
- ❑ Blood Pressure
- ❑ Heart Medication
- ❑ Weight Loss Drugs

Please list your current medications: _____

_____

Allergies and Reactions:

- ❑ Narcotics: _____
- ❑ Antibiotics: _____
- ❑ Anesthetics: _____
- ❑ Other Drugs: _____
- ❑ Latex: _____
- ❑ Non-Medical: _____

Have you had any operations within the last six months? ❑ Yes ❑ No Please list: _____

_____

Please list the operations you have had during your life: _____

_____

Please list the major illnesses you have had during your life: _____

_____

How did you injure yourself?

- ❑ No injury, just started hurting
- ❑ Sports (which sport?) _____
- ❑ Motor vehicle accident
- ❑ Work/Job: Is there a workers comp claim? ❑ Yes ❑ No

Date of Injury? _____

How long have you had Symptoms? _____

Briefly describe your injury: _____

_____

Everything stated above is true and complete to the best of my knowledge and I agree to notify you of any changes.

Patient's Signature: _____ Date: _____

Practitioner's Initials and Date: _____