Today's Date

WARDELL ORTHOPAEDICS, P.C.
Patient Medical History

Patient Information

Name _____
Last *First* *Middle*

AGE _____ Date of Birth _____ Height _____ Weight _____

Office Use Only

Patient ID (Greenway #) _____

Other ID (W.O. #) _____

Past Medical History

- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Heart Disease
- ☐ History of Falls Yes__ No__ Most Recent Fall _____
- ☐ Hypertension/High Blood Pressure
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pulmonary Embolism (PE)
- ☐ Pulmonary/Lung Disease
- ☐ Sleep Apnea
- ☐ Stomach/Intestinal Problems
- ☐ Other _____

Past Surgical History

- ☐ Anesthesia Complications
- ☐ Appendectomy
- ☐ Breast Surgery
- ☐ C-Section
- ☐ Cardiac Stent Placement
- ☐ Cholecystectomy
- ☐ Gastric Bypass
- ☐ Hysterectomy
- ☐ Pacemaker Insertion
- ☐ Spinal Fusion
- ☐ Thyroidectomy
- ☐ Tonsilectomy
- ☐ Total Hip Replacement
- ☐ Total Knee Replacement
- ☐ Total Shoulder Replacement
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Other _____

Family History

- ☐ Blood Clots
- ☐ Bleeding Disorder

Allergy List

- ☐ **No Known Allergy
- ☐ Amoxicillin
- ☐ Augmentin
- ☐ Cardizem
- ☐ Egg
- ☐ Hydrocodone
- ☐ Latex
- ☐ Lisinopril
- ☐ Neurotin
- ☐ Norco
- ☐ Pamelor
- ☐ Penicillin
- ☐ Propofol
- ☐ Prozac
- ☐ Roxicet
- ☐ Shell Fish
- ☐ Sulfa
- ☐ Topamax
- ☐ Tramadol
- ☐ Tylox
- ☐ Other _____

Social History

☐ Tobacco

Current Smoker? ☐ Yes ☐ No If Yes, how much per day? _____

Former Smoker? ☐ Yes ☐ No If Yes, how much and for how long? _____

Current Medications

_____

_____

_____

WARDELL ORTHOPAEDICS, P.C.
Reason for Visit

Today's Date

Patient Identification

Name _____
Last *First* *Middle*

AGE _____ **Date of Birth** _____

Office Use Only

Patient ID (Greenway #) _____
Other ID (W.O. #) _____
Resource _____
Recep. Initials _____

Referring Physician _____

Please provide full name and phone #, if available. _____

Date of Symptoms _____

Date of Injury _____

Family Physician _____

Time of Injury _____ am / pm

Do you have a Durable POA ☐ **Yes** ☐ **No** Living Will ☐ **Yes** ☐ **No** Do Not Resuscitate (DNR) ☐ **Yes** ☐ **No**

Chief Complaints **(Body Parts)** _____

Location of injury **(Street, City and State)** _____

Type of injury **(i.e., auto, pedestrian, bicycle, etc.)** _____

Details of Accident/Injury and/or History of Present Symptoms **(i.e., pain, swelling, numbness, etc.)**

Seen in the Urgent Care Center? ☐ Yes ☐ No **Where?**_____ **Date**_____ **Time** _____ am / pm

Seen in the Emergency Room? ☐ Yes ☐ No **Where?**_____ **Date**_____ **Time** _____ am / pm

X-Rays taken? ☐ Yes ☐ No Where? _____ **Brought films?** ☐ Yes ☐ No

On-The-Job Injury? ☐ **Yes** ☐ **No** **Reported to Employer?** ☐ **Yes** ☐ **No** To Whom? _____

Have you ever been seen by Dr. Wardell or any other Doctor at W.O? ☐ Yes ☐ No **When?**_____

DO NOT WRITE BELOW THIS POINT — OFFICE USE ONLY

MMC On Service? ☐ **Yes** ☐ **No** Seen by W.O. Physician? ☐ **Yes** ☐ **No** Doctor _____ Date Seen _____

Characteristics _____

Previous problems with above area _____

_____ Clinical Initials rev. 5/23