Eastside Orthopedics & Sports Medicine
Medical History Intake Form

Date:

PLEASE PRINT ALL INFORMATION					
NAME:			**DOB:**		
What is your approximate weight?	lbs	Height?	ft	in	
Referred here by: (circle one)	Self	Family	Friend	Doctor	Attorney Other
Name of Person/ Physician making referral:					
List Current Treating Physicians including PCP:			Phone number:		
Describe the reason for your visit:					
Body part to be examined:		Right	Left	Both	
How did your symptoms/injury begin? (describe in detail please)					
Approximate date symptoms began or date of injury:			New or Old injury (circle one)		
Resulting from: (circle which applies)	Sports	Accident	Work Related	Litigation	
What previous form of treatment have you had for this problem? (Medications, therapy, surgery, injections)					

**** DO YOU HAVE ANY DRUG ALLERGIES? ** (circle one) YES NO**

If yes, name the drug and describe the reaction, please be specific. (Example: rash, nausea, shortness of breath, etc)

_____ _____

_____ _____

CURRENT MEDICATIONS:

NAME OF DRUG	REASON FOR USE	DOSAGE INSTRUCTIONS
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PREFERRED PHARMACY NAME: PHONE NUMBER:

ADDRESS:

PAST SURGICAL HISTORY

Previous Type of Operation- Please include year performed

1.	5.
2.	6.
3.	7.
4.	8.

Any previous fractures? YES ☐ NO ☐ Body part?