TALLGRASS
ORTHOPEDIC &
SPORTS MEDICINE

Please indicate by a check (✓) your answer to each question. Your plan of care is based upon your answers, so please answer all questions carefully and accurately. If you are uncertain about an answer place a question mark in the yes column. Explain "yes" answers in Explanations column.

	Yes	No
Tuberculosis		
Emphysema		
Do you Smoke		
Heart Attack(s)		
High Blood Pressure		
Anemia		
Sickle Cell Disease		
Stroke		
Diabetes		
Liver Trouble		
Kidney Disease		
Thyroid Disease		
Stomach Ulcer		

	Yes	No
Have you had blood transfusions		
Do you or any member of your family have problems with anesthesia		
Do you or any member of you family bleed easily		
Do you now, or have you ever abused drugs? If yes, which ones		
Asthma		
Do you drink alcoholic beverages		

If yes
Daily _____ Occasionally _____

Other illnesses not mentioned above

REVIEW OF SYSTEMS

General: Weight Loss Yes ___ No ___

Cardiac: Chest Pain Yes ___ No ___

Respiratory: Shortness of Breath Yes ___ No ___

Neurologic: Numbness Yes ___ No ___
If yes, where:

Immunologic: Infections Yes ___ No ___

Skin: Rashes or Lesions Yes ___ No ___

Hematologic: Bleeding or Bruising Yes ___ No ___

Gastrointestinal: Upset Stomach Yes ___ No ___

Urologic: Difficulty Urinating Yes ___ No ___

If more room is needed, please use back of page

EXPLANATIONS

All previous operations: please list date, procedure and complications, if any.

List all medications: Prescription with dosages

Do you take Herbal Medication? Yes ___ No ___
Please list all Herbal Medication

Height _____ Weight _____

Primary Care Physician:

_____

Update	
Date	Initial
Date	Initial
Date	Initial
Date	Initial

List allergies and adverse medication reactions.

Patient Name: _____ Date: _____