ADVANCED ORTHOPEDICS
AND SPORTS MEDICINE INSTITUTE, PC
A CENTER OF EXCELLENCE FOR BONE AND JOINT CARE

Name: _____

Past Surgical History (include all operations):

	Type	*Approximate Year*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Any previous fractures? ◊ Yes ◊ No Describe _____

Any other serious injuries? ◊ Yes ◊ No Describe _____

List *all medications* currently being taken and explain what each medication is for (include over the counter medications, vitamins, cartilage supplements and birth control pills):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Social History

What is your approximate height? _____ Weight _____ Shoe Size_____

Do you smoke? ◊ Yes ◊ No ◊ Past How much? _____

Do you drink? ◊ Yes ◊ No ◊ Past How much? _____

Have you ever had a problem with drugs? ◊ Yes ◊ No Describe _____

Do you exercise regularly (how much)? _____

What is your occupation? _____

Are you married, single, divorced, etc.? _____

Are you ◊ right handed ◊ left handed

**PLEASE COMPLETE THESE FORMS TO THE BEST OF YOUR ABILITY.
THIS INFORMATION WILL ASSIST YOUR PHYSICIAN IN YOUR TREATMENT.**

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