Center for Orthopaedics and Sports Medicine **Medical Information**

Name ____ Date of Birth _______________

Spouse's Name (if applicable) ____

Chief Complaint ____ Side _______________________

Primary Care Physician ____Fax___________________

Referring Physician ____Fax___________________

Preferred Pharmacy _____________________ Location ______________________________________

Have you ever had a reaction to anesthesia?_____ If yes, what was the reaction _______________________

List All Medications, Dosages, and Times Taken:

Medication (Celebrex)	Dosage (200 mg)	Times a day (1 daily)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Sports/Hobbies _____________________________________ Occupation ______________________________________

Have you ever experienced any of the following?

	Y	N		Y	N		Y	N		Y	N
Frequent Urination/Up at night			Walking Problems			Balance Problems			Rheumatologic Disease		

New Federal guidelines require that we ask: (please circle one)

Ethnicity (culture): Decline, Hispanic or Latino, Not Hispanic or Latino

Race (biological): Decline, American Indian, Asian Indian, Black, Chinese, Filipino, Guamanian, Hawaiian, Hispanic, Japanese, Mart, Multiracial, Samoan, Vietnamese, White

Preferred Language: Decline, English, Spanish

Other relevant social factors: ____

Signature ____ Date ___________________ Age ______