CHATHAM ORTHOPAEDIC ASSOCIATES, P.

ROBERT HOFFMAN, MD
JAMES HOLTZCLAW, MD
MARK JENKINS, DO
GREER NOONBURG, MD
SPENCER WHEELER, MD

**** PLEASE FILL OUT COMPLETELY ****
WE APPRECIATE YOUR TIME AND EFFORT SPENT COMPLETING THIS FORM

Patient Information

NAME	DATE OF BIRTH	AGE	SOCIAL SECURITY #

PRIMARY CARE PHYSICIAN — OFFICE LOCATION

REFERRED BY — OFFICE LOCATION

AFFILIATION: ☐ MEMORIAL ☐ ST.JOE / CANDLER ☐ SOUTHCOAST ☐ OTHER:

HAVE YOU SEEN ONE OF OUR PROVIDERS BEFORE? ☐ YES ☐ NO; LIST PROVIDER: _____ IF SO ☐ NEW PROBLEM ☐ SAME PROBLEM

IS THIS PROBLEM: ☐ WORK RELATED ☐ AUTOMOBILE ACCIDENT ☐ PERSONAL INJURY ☐ HAVE YOU FILED A CLAIM ☐ CONSIDERING FILING A CLAIM

ARE YOU: ☐ RIGHT HANDED ☐ LEFT HANDED — SEX: ☐ MALE ☐ FEMALE

REASON FOR VISIT	☐ RIGHT ☐ LEFT ☐ BOTH	DATE OF ONSET / ACCIDENT

HAVE YOU HAD X-RAYS, MRI / CT OR OTHER STUDIES FOR THIS PROBLEM? ☐ NO ☐ YES IF YES, DID YOU BRING TO VISIT? ☐ NO ☐ YES

HEIGHT	WEIGHT	HOBBY AND SPORT ACTIVITIES YOU ENJOY:
		TYPE OF WORK:

Medical History

**** PLEASE MARK ALL CURRENT AS WELL AS PREVIOUS ILLNESSES ****

☐ YES ☐ NO	HISTORY OF BLOOD CLOTS	☐ YES ☐ NO	HISTORY OF CANCER
☐ YES ☐ NO	HISTORY OF ULCERS	☐ YES ☐ NO	ASTHMA
☐ YES ☐ NO	DIABETES TYPE 1	☐ YES ☐ NO	STROKE(S)
☐ YES ☐ NO	DIABETES TYPE 2	☐ YES ☐ NO	SEIZURE/CONVULSIONS
☐ YES ☐ NO	BLEEDING TENDENCY	☐ YES ☐ NO	HIGH BLOOD PRESSURE
☐ YES ☐ NO	CARDIAC PROBLEMS	☐ YES ☐ NO	THYROID DISORDER
☐ YES ☐ NO	MENTAL ILLNESS	☐ YES ☐ NO	SCOLIOSIS
☐ YES ☐ NO	RHEUMATOLOGIC DISEASE	☐ YES ☐ NO	ARE YOU PREGNANT?

DO YOU HAVE ANY OTHER MEDICAL CONDITION THAT AFFECT YOUR BONES OR JOINTS? EXPLAIN: _____

_____

PLEASE LIST ALL CURRENT MEDICATIONS, SUPPLEMENTS & HERBAL REMEDIES:

☐ **NONE**

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ NO ☐ YES;

PLEASE LIST:

ARE YOU ALLERGIC TO LATEX? ☐ NO ☐ YES

ANY BLOOD THINNERS? ASPIRIN PLAVIX COUMADIN NSAIDS OTHERS

PLEASE LIST ALL PREVIOUS SURGERIES: IF YES, NAME OF SURGEON AND DATE	FALLS IN LAST YEAR? ☐ YES ☐ NO
☐**NONE**	EXPLAIN: _____

ARE THERE ANY ILLNESSES THAT RUN IN YOUR FAMILY? ☐ RHEUMATOLOGIC DISORDERS ☐ CANCER ☐ BLEEDING DISORDERS ☐ HEART PROBLEMS ☐ DIABETES ☐ OTHER:

DO YOU LIVE ALONE? ☐ YES ☐ NO

DO YOU TAKE CARE OF OTHER FAMILY MEMBERS? ☐ YES ☐ NO

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION? _____

FAMILY HISTORY	AGE	MAJOR ILLNESS	IF DECEASED, CAUSE
FATHER			
MOTHER			
BROTHER			
SISTER			

System Review: (To be completed by patient)

Constitutional Systems			**Pulmonary**			**Neurological**		
Good General Health	Yes	No	Disturbed Sleeping	Yes	No	Lightheaded or Dizzy	Yes	No
Recent Weight Change	Yes	No	Shortness of Breath	Yes	No	Tremors	Yes	No
Fever	Yes	No	Chronic/Frequent Cough	Yes	No	Paralysis	Yes	No
Fatigue	Yes	No	Endocrine	Yes	No	Psychiatric	Yes	No
Headaches	Yes	No	Heat or Cold Intolerance	Yes	No	Depression	Yes	No
Eyes	Yes	No	Skin	Yes	No	Memory Loss/Confusion	Yes	No
Wear Glasses	Yes	No	Rash or Itching	Yes	No	Insomnia	Yes	No
Wear Contact Lenses	Yes	No	Psoriasis	Yes	No	Nervousness	Yes	No
Blurred/Double Vision	Yes	No	Genitourinary	Yes	No	Hematologic-Lymphatic	Yes	No
Glaucoma	Yes	No	Frequent Urination	Yes	No	Anemia	Yes	No
Ears-Nose-Mouth-Throat	Yes	No	Burning/Painful Urination	Yes	No	Phlebitis	Yes	No
Hearing Loss or Ringing	Yes	No	Blood in Urine	Yes	No	Past Blood Transfusion	Yes	No
Earaches or Drainage	Yes	No	Kidney Stones	Yes	No	Exposure to HIV	Yes	No
Chronic Sinus Problems	Yes	No	Gastrointestinal	Yes	No	Musculoskeletal	Yes	No
Nose Bleeds	Yes	No	Loss of Appetite	Yes	No	Osteoporosis	Yes	No
Bleeding Gums	Yes	No	Nausea or Vomiting	Yes	No	History of Fractures	Yes	No
Sore Throat	Yes	No	Frequent Diarrhea	Yes	No	History of Arthritis	Yes	No
Cardiovascular	Yes	No	Rectal Bleeding	Yes	No	Rheumatoid Disease	Yes	No
Abnormal Blood Pressure	Yes	No	Abdominal Pain	Yes	No	History of Gout	Yes	No
Chest Pain	Yes	No	Heartburn	Yes	No		Yes	No
Palpitations	Yes	No	Peptic Ulcer	Yes	No		Yes	No
Swelling of feet, ankle or hands	Yes	No	Hepatitis	Yes	No		Yes	No

_____ _____

Patient/Guarantor Signature Date

Reviewed By: _____ M.D. _____

Date