Center of Orthopaedic & Rehab Excellence

Clinton M. Ray, MD
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Name____ Age________ Were you referred by a Physician? Yes_____ No ____

Who requested our service?_______________________________________ Family Physician__________________________________

Reason for seeking medical attention____ Right Left Both

Date of injury or duration of symptoms____________________ Work related? Yes____ No____ Are you right or left handed? Right Left

Have you seen anyone else regarding this condition? Yes____ No____ If yes, list Who & When?__________________________________

Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc? Please list what has been done__________________

Where was study performed?____ When/Dates?____________________________________

Are there any lawsuits such as Auto or Accident pending on your orthopaedic condition? List ____________________________________

***Are you currently in PAIN MANAGEMENT**? Yes____ No____ **If YES, WHERE**_________________________ **PHONE#**______________________

Reason for Pain Management ____

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No
Asthma	___	___	Sickle Cell Disease	___	___
Heart Disease	___	___	Irregular Heartbeat	___	___
Bleeding Tendencies	___	___	Tuberculosis	___	___
Epilepsy	___	___	Stomach Ulcers	___	___
High Blood Pressure	___	___	Alcoholism	___	___
Anemia	___	___	Depression/Anxiety	___	___
Nervous System Disorder	___	___	Cancer	___	___
			Stroke/When? ____________________		

*If you have **any** of the following, please list **Type:***

Arthritis ________________________________
Lupus ___________________________________
Kidney disease ____________________________
Hepatitis _________________________________
Lung disease ______________________________
Thyroid disease ____________________________
Diabetes _________________________________
Bone Conditions____________________________

Other Medical Conditions ____

Do you currently use tobacco: cigarettes______ pipe______ smokeless______ amount per day_________ Quit when?__________
Do you drink alcohol: beer______ liquor______ wine______ amount per day__________________ or week_____________

Has anyone in your family had:
Cancer______________________________ Bone Conditions______________________________ Bleeding Problems______________
If yes, list relationship and what type?

Please list **All Orthopaedic surgeries** and **dates:**

____
____
____
____
____

Please list **All other surgeries** and **dates:**

____
____
____
____
____

Please list all current medications and dosages: ***PREFERRED PHARMANY***____

_______________________________ ___________________________________ ________________________________
_______________________________ ___________________________________ ________________________________
_______________________________ ___________________________________ ________________________________

Check if you Are you allergic to: Dyes________ Latex________ Penicillin________ Mycins________ Sulfa________ Tetanus________
Cephalosporin________ Aspirin________ Codeine________ Iodine________ Morphine________ Adhesive Tape________
Arthritis Medicines________ Foods (Please list):____
Other Allergies: ____
Height________ Weight________

Patient's Signature_______________________________ Physician's Signature___________________________ Date_____________

EMAIL ADDRESS:____