SPIVEY
ORTHOPEDIC CLINIC

*Board-Certified, Sports Trained Orthopedic Surgeon * Specializing in General Orthopedics and Sports Medicine*

Patient Name: _____ Birthdate: _____

PAST MEDICAL HISTORY (Not Orthopedic Related)

o Anxiety	o Asthma	o Atrial Fibrillation
o Bipolar Disorder	o Chronic Anemia	o Chronic Obstructive Lung
o DiseaseChronic Pain	o Coronary Arteriosclerosis	o Deep Venous Thrombosis
o Depression	o Diabetic On Insulin	o Disease Caused by 2019-nCoV
o End-Stage Renal Disease	o Epilepsy	o Hypertension
o Gastroesophageal Reflux	o Hyperparathyroidism	o Hx of Radiation Therapy
o HIV	o Hypercholesterolemia	o Hyperthyroidism
o Hypothyroidism	o Inflammatory Disease of the Liver	o Ischemic Heart Disease
o Leukemia	o Malignant Lymphoma	o Morbid Obesity
o Obstructive Sleep Apnea	o Fibromyalgia Syndrome	o Pulmonary Embolism
o Type 2 Diabetes Mellitus	o Malignant Tumor of: oBreast oColon oLung oProstate	

Other:_____

_____

PAST SURGERIES (Not Orthopedic Related)

o Bypass of Stomach	o Coronary Artery Bypass	o Kidney Transplant
o Colostomy	o Colectomy	o Pancreatectomy
o Liver Excision	o Coronary Angioplasty	o Heart Valve Replacement
o Heart Transplant	o Liver Transplant	o Low Anterior Rectum Resection
o Mechanical Heart Valve Replacement		o Mastectomy: o Left o Right o Bilateral

Other:_____

_____

MUSCULOSKELETAL DISEASE (Orthopedic Related)

o Ankylosing Spondylitis	o Bursitis	o Chronic Low Back Pain
o Rheumatoid Arthritis	o Compression Fracture	o Osteoarthritis
o Osteoporosis	o Idiopathic Scoliosis	o Malignant Neoplasm of Bone
o Gout	o Prolapsed Cervical Disc	o Prolapsed Lumbar Disc
o Psoriasis w/ Arthropathy	o Rickets	o Sarcoma of Bone
o Sciatica	o Cervical Spinal Stenosis	o Lumbar Spinal Stenosis
o Vitamin D Deficiency	o Osteopenia	o Vertebral Epidural Steroid Injection

o Adhesive Capsulitis of Shoulder	o Right	o Left
o Carpal Tunnel Syndrome	o Right	o Left
o Shoulder Impingement	o Right	o Left

Fracture of: List Body Part and Side:: _____

Other:

_____

_____

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MUSCULOSKELETAL SURGICAL HISTORY (Orthopedic Related)

oRight o Left oBilateral: _____

oRight o Left oBilateral: _____

oRight o Left oBilateral: _____

oRight o Left oBilateral: _____

MUSCULOSKELETAL FAMILY HISTORY

o Diabetes o Hypertension o Multiple Hereditary Exostosis
o Osteoarthritis o Osteoporosis o Scoliosis
Other:

_____

CURRENT MEDICATIONS / SURESCRIPT CONSENT

I consent for Spivey Orthopedic Clinic to import my medication list from Surescript.

_____**(Initial/Date)**

If you do not consent to the above statement, list your Medication Name(s) and Dosage Below:

_____

_____

ALLERGIES

List all allergies below.

_____

_____

SOCIAL HISTORY

What is your smoking status? o Never o Former o Heavy o Light
Do you consume alcohol? oNone o Less than 1/day o1-2 per day o3+ per day
Do you use recreational drugs? o Yes oNo

FAMILY HISTORY

o Diabetes o Heart Disease o Hypertension o Bleeding Problems
o Epilepsy o Connective Tissue o Muscular Dystrophy o Stroke
o Cancer o Osteoporosis o Rheumatoid Arthritis
Other:

_____

X _____ DATE: _____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)