

**ATLANTIC ORTHOPAEDICS**  
**PATIENT HEALTH INFORMATION**  
**PLEASE COMPLETE EACH QUESTION**

Name \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

What is the reason for today's visit \_\_\_\_\_  
\_\_\_\_\_

When and how did this problem begin \_\_\_\_\_  
\_\_\_\_\_

Family Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

**HEALTH HISTORY**

If you have ever had the following, please circle:

Asthma                      High Blood Pressure      Diabetes      Seizures      Peptic Ulcer Disease

Heart Disease      Emphysema      Hepatitis      Cancer (type) \_\_\_\_\_

If so when \_\_\_\_\_

Please list all surgeries you have had \_\_\_\_\_  
\_\_\_\_\_

Please list you current medications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications. If so, what is the reaction \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_