TRI-STATE ORTHOPAEDICS & Sports Medicine, Inc.

Additional Health / History Information

Name: _____ DOB: _____ Age: _____

Height: _____ (ft) _____ (inches) Weight: _____ (lbs) Male / Female

Employer: _____ Occupation: _____

Indicate **primary problem** and body part affected/injured (right or left) and when it started : _____

_____

Did you have any **prior treatment or surgery** for this problem prior to your visit? Yes / No

If "Yes", when and describe: _____

_____

Were X-Rays or MRI taken? Yes / No If "Yes", did you bring the films with you today? Yes / No

If "Yes" when _____ and where (what facility)?_____

List all medications you are taking (include prescription and over-the-counter such as aspirin, vitamins, dietary supplements, etc.)

MEDICATION NAME / DOSAGE / FREQUENCY / ROUTE	MEDICATION NAME / DOSAGE / FREQUENCY / ROUTE
1. _____/_____/_____/_____	6. _____/_____/_____/_____
2. _____/_____/_____/_____	7. _____/_____/_____/_____
3. _____/_____/_____/_____	8. _____/_____/_____/_____
4. _____/_____/_____/_____	9. _____/_____/_____/_____
5. _____/_____/_____/_____	10. _____/_____/_____/_____

Medication Allergies: _____

Pharmacy Name: _____ **Phone:** _____

Address (street/city): _____ **Fax:** _____

Emergency Contact: Name: _____ **Relationship:** _____

Phone number(s): _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Race: □ White □ Black/African American □ American Indian/Alaska Native □ Asian
□ Native Hawaiian or Pacific Islander □ Declined

Language □ English □ Spanish □ Sign Language □ Other_____

The information provided above is complete and accurate. With my signature, I confirm it is true and correct.

Signature_____ **Date:**_____