Richards Orthopaedic Center and Sports Medicine
144 South Eighth Street Suite 107
Chambersburg, PA 17201
717-414-7798

Patient's Name:_____Date of Birth:_____

Primary Care Physician:_____Today's Date:_____

Past Medical History: Check any illnesses you may have or have had in the past.

__ NONE __ Blood Clots __ Osteoporosis
__ Gastric Ulcer __ High Blood Pressure __ Heart Attack
__ Osteoarthritis __ Diabetes __ Stroke
__ Rheumatoid Arthritis __ HIV __ Bleeding Disorder
__ Cancer: specify_____
__ Hepatitis: specify_____
__ Other: _____

Past Surgical History: Check any surgeries that you have already had.

__ NONE __ Appendectomy __ Gall Bladder __ Vascular bypass
__ Heart Surgery __ Hysterectomy __ Tonsillectomy __ Carpal Tunnel
__ Total Joint Replacement: specify_____ __ Back Surgery: specify _____
__ Fracture Repair: specify_____ __ Other: _____

Family History: Check all that apply for your family

Father has __ Arthritis __ Diabetes __ Heart Disease __ Stroke __ Cancer __ Deceased, Other: ____
Mother has __Arthritis __ Diabetes __ Heart Disease __ Stroke __ Cancer __ Deceased, Other:_____
Brother has __Arthritis __Diabetes __ Heart Disease __ Stroke ___Cancer __ Deceased, Other:_____
Sister has __Arthritis __Diabetes __ Heart Disease __ Stroke ___Cancer __ Deceased, Other:_____
List family history of orthopedic problems:_____

For females over 64 years old: Did you ever have a Dexascan (Xray to check for Osteoporosis)? __no __yes
If so, where: _____ If not, would you like an order for one? __no __yes G8399

Allergies: Check any that apply

__ NO KNOWN DRUG ALLERGIES
__ Demerol __ Anesthetic __ Penicillin __Iodine
__ Morphine __ Aspirin __Codeine __ Sulfa
__Other:_____

Medications: Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, and heart medications.

__ No current medications

NAME	Strength	Frequency	NAME	Strength	Frequency

Do You Smoke or Chew Tobacco? Yes____ No____ ***If no****, never ____ or only in the past _____*
If yes*, do you smoke more than 10 cigarettes_____ or 10 or fewer cigarettes a day _____*
Do you chew? _____

Patient's Name:_____Date of Birth:_____

Review of Systems

In the last three months, have you had any of these symptoms? **If no, mark NONE.**

						NONE	Details
1)	CON	__ Weight Loss	__ Loss Of Appetite			☐	
2)	EYE	__ Blurred Vision	__ Double Vision	__ Vision Loss		☐	
3)	ENT	__ Hearing Loss	__ Hoarseness	__ Trouble Swallowing		☐	
4)	CV	__ Chest Pain	__ Palpitations			☐	
5)	RS	__ Chronic Cough	__ Shortness of Breath			☐	
6)	GI	__ Heart burn	__ Ulcers	__ Nausea	__ Vomiting	☐	
		__ Blood in Stools	__ Hepatitis	__ Liver disease		☐	
7)	GU	__ Painful Urination	__ Blood in Urine	__ Kidney problems		☐	
8)	SK	__ Frequent Rashes	__ Skin Ulcers	__ Lumps	__ Psoriasis	☐	
9)	NEU	__ Headaches	__ Dizziness	__ Seizures		☐	
10)	PSY	__ Depression	__ Drug/Alcohol Addiction	__ Sleep disorder		☐	
11)	ENDO	__ Thyroid disease	__ Heat or Cold Intolerance			☐	
12)	HEM	__ Easy bleeding	__ Easy Bruising	__ Anemia		☐	
13)	Are you HIV Positive?	__ No	__ Yes				

The above information is true to the best of my knowledge.

Please sign here - Patient Signature (parent for minors): _____ Date _____