SUTTON
ORTHOPAEDICS & SPORTS MEDICINE, P.C.
(770) 389-8386 Fax (770) 507-9576

Name: _____ Today's Date: _____

SS#: _____ Date of Birth: _____

Chief Complaint

Why are you seeing the doctor today? _____

Current problem is the result of a(n): **Check** all that apply

❒ Car Accident ❒ Work Accident ❒ Accident How Accident Happened

❒ Other Date of Injury_____ _____

Medications

List medications you are currently taking, and any herbal medications.

Allergies

Are all immunizations up to date? ❒ Yes ❒ No

If no, which immunizations are due? _____

Social History

☐ Work in the home ☐ Employed (occupation)_____ Where Employed _____

Yrs of Employment_____ ☐ Student ☐ Daycare ☐ Retired

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ No ☐ Yes #_____

Do you live alone? ☐ No ☐ Yes _____

Do you exercise ? ☐ Daily ☐ Weekly ☐ Monthly

☐ Rarely ☐ Never What Type of Exercise?_____

History of substance abuse? ☐ No ☐ Yes What? _____

Smoke currently? ☐ No ☐ Yes

_____Packs per day for _____ years.

Quit smoking? _____ When _____ Previously smoked _____ packs per day for _____ years.

Drink alcohol? ☐ No ☐ Daily ☐ 1-2x1 week ☐ 1-2x1 month ☐ 1-2x1 year

Are you pregnant_____Yes _____No Due Date _____

Patient Signature: _____ Date: _____

Reviewed: _____ MD Date: _____

(Over)

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Past Medical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? No Yes

Have any problems with anesthesia? No Yes Describe: _____

Review of Systems - Are you currently having or have you had problems with your

	Circle		Describe all Yes
Eyes	No	Yes	
Ears, Nose, Throat	No	Yes	
Lungs, Breathing	No	Yes	
Digestion	No	Yes	
Bowel movement	No	Yes	
Bladder problem	No	Yes	
Diabetes	No	Yes	
Heart	No	Yes	
High blood pressure	No	Yes	
Bleeding problems	No	Yes	
Balance problems	No	Yes	
Numbness / tingling	No	Yes	
Blackout / fainting	No	Yes	
Psychological problems	No	Yes	
AIDS	No	Yes	
Cancer	No	Yes	
Arthritis	No	Yes	
Polio	No	Yes	
TB	No	Yes	
Epilepsy	No	Yes	
Other			

Patient Signature: _____ Date: _____