DONALD CLINTON MORRIS, JR., M.D., P.A.
Orthopaedic Surgery and Sports Medicine

WORK RELATED? Yes or No **AUTO ACCIDENT**? Yes or No

DATE: _____ Name _____ Age: _____ Height: _____ Weight: _____

REASON for seeking medical attention _____ **DATEof injury or duration of symptoms**_____

PLEASE INDICATE: Right Left Both **Severity of Pain** (circle) 0 1 2 3 4 5 6 7 8 9 10

HOW & **WHERE** did injury/problem occur?_____

Have you had any diagnostic studies for this condition, such as MRI, bone scan, x-rays, etc.? Please list _____

Have you seen anyone else regarding this condition? Yes or No If yes, list names and dates_____

Are there law suits pending on your orthopedic condition?_____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING ITEMS:

Have you EVER been diagnosed with any of the following medical conditions?: If no, circle NONE

YES NO Alcoholism
YES NO Anemia
YES NO Anxiety
YES NO Asthma
YES NO Bleeding Tendencies
YES NO Blood clots/DVT/PE
YES NO Cancer (TYPE:_____)
YES NO CHF
YES NO Colitis
YES NO COPD
YES NO Depression
YES NO Diabetes (*Please specify I or II*)
YES NO Emphysema
YES NO Epilepsy
YES NO Heart Disease/ Arrhythmia/MI
YES NO Hepatitis
YES NO High Blood Pressure
YES NO Kidney Disease
YES NO Lung Disease
YES NO Lupus
YES NO Migraines
YES NO Nervous System Disorder
YES NO Osteoarthritis
YES NO Pacemaker
YES NO Polio
YES NO Rheumatoid Arthritis
YES NO Sickle Cell Disease
YES NO Stroke/TIA
YES NO Stomach Ulcers
YES NO Thyroid Disease/Goiter
YES NO Tuberculosis
YES NO Other: _____

Have you RECENTLY had any of the following symptoms? If no, circle NONE

YES NO Fever or Chills
YES NO Weight Loss
YES NO Change in Vision
YES NO Headaches/Migraines
YES NO Dizziness
YES NO Chest Pain
YES NO Irregular Heart Beat
YES NO Fainting Spells/Syncope
YES NO Shortness of Breath
YES NO Cough
YES NO Cough with Blood
YES NO Nausea
YES NO Vomiting
YES NO Diarrhea
YES NO Abdominal Pain
YES NO Bloody or Black Tarry Stools
YES NO Urinary Urgency
YES NO Urinary Frequency
YES NO Pain/Burning on Urination
YES NO Loss of Control of Bladder
YES NO Difficulty Voiding
YES NO Tingling or Numbness

ARE YOU ALLERGIC TO: If no, circle NONE

YES NO Adhesive Tape
YES NO Arthritis Medicines
YES NO Aspirin
YES NO Cephalosporin
YES NO Codeine
YES NO Dyes
YES NO Iodine / shellfish
YES NO Latex
YES NO Morphine
YES NO Mycins
YES NO Penicillin
YES NO Sulfa
YES NO Tetanus
YES NO Other medication: _____

_____

_____

TOBACCO USE: (Must answer)

Never: ___ Former:___ Age Quit:____
Current:___
Cigar/Cigarettes:___ Chew:____

Amount per day: _____

ALCOHOL USE:

Non Drinker:___

Beer:__ Liquor: ___Wine:___

Amount per Week: ___

Please list any orthopedic surgeries & dates: If none, circle **NONE**.
_____
_____

Please list any other surgeries & dates: If none, circle **NONE**: _____
_____

FAMILY MEDICAL HISTORY:

Diabetes: ___ Heart Disease: __
Lung Disease:___
High Blood Pressure:___
Cancer:___
Type:_____

Please list all current **MEDICATIONS AND DOSAGES**: *(If you have a list we can copy it, or if you do not take medications, please answer* **NONE**).

_____ _____ _____

_____ _____ _____

PATIENT'S SIGNATURE _____