TIGARD ORTHOPEDIC & FRACTURE CLINIC

Date: ________________

Name: ____________________________________**Age:**_____ **Male/Female**

Occupation: ______________________**Employer:**_______________________ **Full time/Part time**

Height:_______ **Weight**:_______ **Do you smoke?** _________ **Do you drink?** _________

Current & Past Medical Conditions:

☐ High Blood Pressure ☐ Seizure or Stroke ☐ Irregular heart beat ☐ Emphysema/Chronic Bronchitis
☐ Cancer (type)________ ☐ Diabetes (type)_________ ☐ Hepatitis ☐ Hypothyroid Disorder
☐ Hyperthyroid Disorder ☐ Bleeding Disorder ☐ High Cholesterol ☐ Sleep Apnea
☐ Other: ____

____

Current Medications:

1. ________________________ 4. ________________________ 7. ________________________
2. ________________________ 5. ________________________ 8. ________________________
3. ________________________ 6. ________________________ 9. ________________________

Do we have permission to download your medications from your pharmacy? ☐ Yes ☐ No

Pharmacy: ____

Allergies: ____

____

List all past surgeries and dates if known: ____

____

Family History: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Hypertension

Have you had any of the following?	Yes	No
Recent Weight Change? Gain or Loss		
Fatigue?		
Rash?		
Vision Changes?		
Glasses or Contacts?		
Cough?		
Wheezing?		
Asthma?		
Chest Pain?		
Palpitations?		
Constipation?		
Abdominal Pain?		
Muscle or joint pain?		
Mental status change?		
Abnormal bleeding?		
Excessive thirst or hunger?		