CalvertHealth Medical Group

Orthopedics & Sports Medicine
New Patient Information

Patient Name: _____ **Today's Date:** _____

Height: ____ *ft.* ____ *in.* **Weight:** ____ *lbs.* ☐ Male ☐ Female ☐ Other **DOB:** _____ **Age:** ____

Marital Status: ☐ Single ☐ Married **Work Phone:** _____ **Cell Phone:** _____

Email: _____ **Occupation:** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Primary Care Provider: _____ **Referring Provider:** _____

What pharmacy do you use? Please include name and city _____

Do you see a cardiologist? ☐ No ☐ Yes, Physician's Name: _____

VISIT INFORMATION

Reason for today's visit: _____

Length of condition? _____ **Location of condition?** _____

Have you previously had surgery for this? ☐ No ☐ Yes, Explain: _____

Were you seen in an ER or Urgent care or this? ☐ No ☐ Yes, Explain: _____

What imaging tests have you had on this? _____

Previous treatments? _____

Did it occur while working on a job? ☐ No ☐ Yes **Did it occur in an auto accident?** ☐ No ☐ Yes

Dexterity: ☐ Right-handed ☐ Left-handed

CURRENT MEDICATIONS: Please list all current medications

Name of Medication (example: Tylenol)	**Dosage** (Example: 500Mg)	**# of times per day** (Example: 1 pill two times a day)

Allergies: ☐ No Known Allergies ☐ Medication Allergies ☐ Latex Allergy

Please list any drug, food, or contact allergies: _____

AMB.NEWPT

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Patient Name: _____ **DOB:** _____

MEDICAL HISTORY: Please check all that apply

Cardiovascular
- ☐ Hypertension
- ☐ MI/CAD
- ☐ A-Fib/Arrhythmia
- ☐ Pacemaker/AIDC
- ☐ Valvular Disease
- ☐ Coronary Stent
- ☐ Hyperlipidemia
- ☐ OTHER: _____

Pulmonary
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ OTHER: _____

Neuromuscular
- ☐ TIA or Stroke
- ☐ Seizures
- ☐ Psychiatric Disorder
- ☐ Anxiety/Depression
- ☐ OTHER: _____

GI Endocrine
- ☐ Reflux/Gastritis
- ☐ Hepatitis, Type: _____
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Diverticulitis
- ☐ Diabetes, Type: _____
- ☐ OTHER: _____

Hematologic
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Chemotherapy
- ☐ HIV/AIDS
- ☐ Cancer, Type:_____
- ☐ OTHER: _____

Conditions not listed: _____

_____

_____

PAST SURGICAL HISTORY: Please list previous surgeries

Type of Surgery	Date of Surgery

Have you ever experienced bleeding problems or blood clots during or after surgery?
☐ No ☐ Yes, Explain: _____

Have you ever experienced problems with anesthesia in the past?
☐ No ☐ Yes, Explain: _____

FAMILY HISTORY: Do you have any family history of:

Blood Clots ☐ No ☐ Yes, Explain: _____

Anesthesia Complications ☐ No ☐ Yes, Explain: _____

SOCIAL HISTORY

Tobacco Use

Do you currently smoke? ☐ No ☐ Yes, Explain: _____

Have you previously smoked? ☐ No ☐ Yes, Explain: _____

Do you Vape? ☐ No ☐ Yes

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes, Explain: _____

Marijuana Use

Do you use marijuana? ☐ No ☐ Yes, Explain: _____

Do you use any recreational or illegal drugs? ☐ No ☐ Yes, Explain: _____