



ALLIED ORTHOPAEDICS

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Patient Profile

In order to provide you with quality care, it is necessary to know your medical history. This profile is part of your medical record and is strictly confidential. Please answer the following questions to the best of your knowledge.

Name: _____ DOB: _____ AGE: _____ DATE: _____

Health History

Do you now or have you recently had any of the following (please circle)

Fever/Chills	Y N	Blurred Vision	Y N	Breathing Prob	Y N
Chest Pain	Y N	Sore Throat	Y N	Nausea	Y N
Rashes	Y N	Headaches	Y N	Urination Prob	Y N

Any other health problems? Y N If yes, please list:

Any medication allergies? Y N If yes, please list:

Do you take any medications? Y N If yes, please list:

Are you or could you be pregnant? Y N

Have you had any previous surgeries? Y N If yes, please list:

Work Status: Employed Y N If yes, occupation? _____

Is there anything else our staff should know to assist with your treatment?

Patient Signature (or Guardian if patient is under 18)

Date