

JOHN L. STANTON, M.D., P.C., FAAOS



KEITH D. STARKWEATHER, M.D., P.C., FAAOS

An Association of Physicians

Specializing in Orthopaedic Surgery and Sports Medicine

**PATIENT INFORMATION**

TODAY'S DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_ BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_ RACE: \_\_\_\_\_

SS#: \_\_\_\_\_ MARITAL STATUS: MARRIED \_\_\_\_ DIVORCED \_\_\_\_ WIDOWED \_\_\_\_ SINGLE \_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK TELEPHONE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

PARENT/GUARDIAN (IF PATIENT IS MINOR): \_\_\_\_\_

IN CASE OF EMERGENCY: NAME OF CONTACT \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY CONTACT TELEPHONE NUMBER: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_ LOCATION: \_\_\_\_\_

WHO REFERRED YOU FOR TODAYS APPOINTMENT: \_\_\_\_\_

REASON FOR YOUR VISIT TODAY/DESCRIBE PROBLEM: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOW LONG HAVE YOU HAD THIS PROBLEM: \_\_\_\_\_ HAVE YOU HAD PRIOR TREATMENT: \_\_\_\_\_

TESTS PERFORMED FOR THIS PROBLEM (X-RAY'S, MRI'S, ETC.): \_\_\_\_\_

WHERE WERE TESTS PERFORMED: \_\_\_\_\_

ARE YOU HERE TODAY DUE TO AN ACCIDENT: NO \_\_\_\_ YES \_\_\_\_ IF YES, DATE OF ACCIDENT: \_\_\_\_\_

WAS THIS ACCIDENT WORK RELATED: \_\_\_\_ HOME RELATED: \_\_\_\_ OTHER: \_\_\_\_

DESCRIBE HOW THIS ACCIDENT OCCURRED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION**

DO YOU SMOKE? YES \_\_\_ NO \_\_\_ IF YES, HOW OFTEN? \_\_\_\_\_

A: HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

B: DO YOU TAKE ASPIRIN PRODUCTS: \_\_\_\_\_ IF YES, HOW MANY & HOW OFTEN \_\_\_\_\_

C: ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOOD: \_\_\_\_\_ IF YES, PLEASE LIST BELOW:

MEDICATION/FOOD

YOUR REACTION

---

---

---

D: DO YOU HAVE A LATEX ALLERGY: YES \_\_\_ NO \_\_\_

E. ARE YOU ALLERGIC TO TAPE: YES \_\_\_ NO \_\_\_

F. ARE YOU ALLERGIC TO BETADINE: YES \_\_\_ NO \_\_\_

G: LIST MEDICATIONS YOU ARE TAKING NOW: NONE \_\_\_\_\_

MEDICATION

DOSAGE

HOW OFTEN

---

---

---

---

---

---

---

---

---

H: HAVE YOU EVER BEEN HOSPITALIZED, HAD SURGERY, HAD A FRACTURE OR BROKEN BONE: \_\_\_\_\_  
IF YES, PLEASE LIST BELOW:

HOSPITALIZATION/SURGERY/FRACTURE/BROKEN BONE

WHEN

PHYSICIAN

---

---

---

---

**I: HAVE YOU HAD ANY TYPE OF REACTION TO ANESTHESIA DURING SURGERY:** \_\_\_\_\_

**IF YES, WHAT KIND OF REACTION:** \_\_\_\_\_

**J: WHAT OTHER HEALTH PROBLEMS DO YOU HAVE OR HAVE YOU HAD: NONE** \_\_\_\_\_

<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> SLEEP APNEA
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> SNORING
<input type="checkbox"/> DIABETES	<input type="checkbox"/> STROKES	<input type="checkbox"/> CPAP/BiPAP
<input type="checkbox"/> BLEEDING PROBLEMS	<input type="checkbox"/> BLOOD TRANSFUSIONS	<input type="checkbox"/> HEART ATTACK
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART FAILURE	<input type="checkbox"/> EMPHYSEMA
<input type="checkbox"/> ANGINA	<input type="checkbox"/> ASTHMA	
<input type="checkbox"/> OTHER		

---

**K. DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE OR HAD ANY OF THE FOLLOWING:**

<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> SLEEP APNEA
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> SNORING
<input type="checkbox"/> DIABETES	<input type="checkbox"/> STROKES	<input type="checkbox"/> CPAP/BiPAP
<input type="checkbox"/> BLEEDING PROBLEMS	<input type="checkbox"/> BLOOD TRANSFUSIONS	<input type="checkbox"/> HEART ATTACK
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART FAILURE	<input type="checkbox"/> EMPHYSEMA
<input type="checkbox"/> ANGINA	<input type="checkbox"/> ASTHMA	
<input type="checkbox"/> OTHER		

---

**L. PLEASE COMMENT ON ANY ADDITIONAL INFORMATION THAT YOU FEEL WE NEED TO KNOW:**

---

---

---

