Gavin Orthopaedics, LLC | The Sport & Spine Institute

Initial Visit Sheet

Name: _____ Date:_____

Date of Birth _____

Allergies: Reactions

_____

_____

_____

_____

Current Medications:

Medication Dose Reason for medication

_____

_____

_____

_____

_____

Past Medical Problems: ✔ Items if Yes and Explain

Alcoholism	☐	_____	Heart Disease (specify)	☐	_____
Arthritis (Specify type)	☐	_____	High Blood Pressure	☐	_____
Asthma	☐	_____	Hepatitis (type)	☐	_____
Anemia	☐	_____	HIV/AIDS	☐	_____
Blood/Bleeding Problems	☐	_____	Kidney Problems	☐	_____
Cancer	☐	_____	Osteoporosis	☐	_____
Chronic Lung Disease	☐	_____	Polio	☐	_____
Cirrhosis of Liver	☐	_____	Prostate Problems	☐	_____
Colon or Bowel Trouble	☐	_____	Stroke	☐	_____
Convulsions/Seizures	☐	_____	Stomach or Duodenal Ulcer	☐	_____
Deafness/Hard of Hearing	☐	_____	Sexually Transmitted Diseases	☐	_____
Diabetes	☐	_____	Skin Disease	☐	_____
Emotional Problems	☐	_____	Tuberculosis	☐	_____
Glaucoma	☐	_____	Thyroid Problems (specify)	☐	_____
Gout	☐	_____	Vericose Veins	☐	_____

Surgeries:		**Date**	**Other Surgeries:**		**Date**
Tonsillectomy	☐	____/____/____	_____	☐	____/____/____
Appendectomy	☐	____/____/____	_____	☐	____/____/____
Hernia Repair	☐	____/____/____	_____	☐	____/____/____
Gall Bladder	☐	____/____/____	_____	☐	____/____/____
Hysterectomy	☐	____/____/____	_____	☐	____/____/____

Social History:

Marital Status ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Do you drink alcohol? ☐ Never ☐ Socially ☐ Rarely ☐ Moderately ☐ Heavy Drinker ☐ Recovering Alcoholic

Do you smoke? ☐ Never ☐ Yes Amount?_____ ☐ Former Smoker - Quit when?_____

Height: Feet_____ Inches_____

Weight_____ Recent Weight Gain or Loss - Amount_____

Current Job Description_____ Duties_____

Do you live in (Circle) One story Home Apartment Two story Home

Do you have bathroom facilities on the first floor? ☐ Yes ☐ No

_____ _____

Patient Signature Date Physician Signature