Orthopaedic Specialists of Central Arizona

Judah D Pifer, MD • Brad D Williams, MD

Body part: ____________________ Right Left Bilateral (Circle one)

Last Name:______________________________ First Name: ____________________________ MI: _______

Date of Birth:________________Age: ________ Primary Care Doctor: ________________________________

Were images taken? (Xrays or MRI) No # Yes # If yes, where? _____________________________________

Since your last visit, has your pain recently: # Worsened # Not changed # Improved # Gone away

Have you taken any medications for your pain?

□ Tylenol # NSAID's # Narcotic pain pills # Glucosamine/Chondroitin/MSM-type supplements

Have you had any prescribed treatment for your pain?

□ Physical Therapy # Cortisone injections # Lubricating injections (Synvisc, Supartz, Euflexxa)

Other: ____

Do you use a cane, crutches, or a walker? No # Yes # If yes, please circle which one.

Do you wear a brace? No # Yes #

Please list all operations you have had since your last visit (name and date):

____

____

Do you smoke or chew tobacco (please circle) No # Yes # If yes, how much and for how long?_____________

Please indicate any and all medical conditions for which you have been treated:

Under current active or past treatment?	Current	Past	*Under current active or past treatment?*	Current	Past
Heart disease or heart attack (circle)			Gastritis/Reflux disease (circle)		
Pacemaker			Leukemia/Lymphoma (circle)		
Congestive heart failure			Thyroid disease		
Irregular heart beat			Liver disease or Cirrhosis (circle)		
Hypertension (High blood pressure)			Kidney disease		
Diabetes			Bladder infection		
Blood clots in your legs or lungs (circle)			Prostate difficulty		
Stroke			Severe body aches/ Fibromyalgia (circle)		
Osteoporosis (weak bones)			**Medical Implants:**		
Bleeding problems / Anemia (circle)			MRSA infection		
COPD/Emphysema/Bronchitis (circle)			Tuberculosis		
Sleep Apnea			HIV/AIDS		
Stomach/Intestinal Ulcer (circle)			Rheumatoid Arthritis		
Other:			Other:		

By signing below, I certify that I understand the questions and have answered honestly and to the best of my knowledge.

Signature: ____ Date: _______________________

Printed Name: _____________________________________

*We, at OSCA, assure you that the above information is part of your personal and private medical record. As such, it will not be shared with anyone outside this office without your specific, written permission, except for circumstances wherein we are required to do so by law.

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MEDICATION LIST

PATIENT NAME: ___________________________________ DATE OF BIRTH: __________________

ALLERGIES: Drugs/ Foods	REACTIONS/Side Effects	ALLERGIES: Drugs/ Foods	REACTIONS/Side Effects

Please list all medications you currently take, including Prescriptions, Over-the-Counter, Patches, Inhalers, Vitamins, Herbal Supplements and Eye drops.

DRUG NAME	DOSE	ROUTE e.g. oral, injectable, inhaled	FREQUENCY	REASON

*Current Mailing Address: ____

*Current Phone Number: ______________________________

Patient Signature: _____________________________________ Date: ___________________

Reviewing Staff: _______________________________________

Reviewing Staff Signature: _______________________________ Date: ____________________