

Fondren Orthopedic Group L.L.P.
J. Kevin Horn, M.D.

Date: _____

Patient Name: _____ Sex: M/F Age: _____
(Last) (First) (MI)

Date of Birth: _____ Marital Status: _____ SS#: _____ - _____ - _____

Home Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Employer: _____
(Name) (Address)

Occupation: _____ Work Phone: _____ - _____ - _____

Name of nearest relative not living with you: _____

Relationship: _____ Phone #: _____ - _____ - _____

Insured or Guarantor's Name: _____ Relationship: _____

Date of Birth: _____ SS#: _____ - _____ - _____

Insured Work Phone: _____ - _____ - _____ Employer: _____

Describe in detail how and when injury or symptoms first began:

Is this due to an injury while at work? Yes ___ No ___

Is this injury due to a car accident? Yes ___ No ___

Have you been treated by another physician for this injury or symptoms?

Yes ___ No ___

If so, by which physician? _____

Patient Name: _____
 Age: _____ Height: _____ Weight: _____ Male / Female

Please state the reason for your appointment today? (Specify (L) left or (R) right) _____

List all previous surgeries: _____

List all current medications: _____

List all drug allergies: _____

	Yes	No
Have you ever had a problem with an anesthetic other than nausea?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sleep apnea?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had pneumonia recently?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asbestosis?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have COPD?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high cholesterol?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pace maker?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of heart disease? Treating Doctor? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a heart attack?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have coronary artery disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stress test?....If yes, when?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have epilepsy or seizure disorder? Treating Doctor? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a hiatal hernia, acid reflux, or an ulcer?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had Hepatitis, HIV, or jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have tuberculosis or ever had a positive TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes? For how long?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any bleeding disorders or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken aspirin, Plavix, Coumadin, or Lovenox in the last week?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have bipolar disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of polio?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have gout?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cancer? History of cancer? (Type).....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any medical condition(s) not listed above?	<input type="checkbox"/>	<input type="checkbox"/>

Do you or have you ever smoked? Yes ___ No ___ If so, how much per day? _____

Do you drink alcohol? Yes ___ No ___ If so, how much? _____

Do you have a history of drug or alcohol abuse? Yes ___ No ___

Are your immunizations up to date? Yes ___ No ___