

MEZONA ORTHOPAEDIC PROFESSIONAL ASSOCIATION

2940 E. Banner Gateway Dr., Suite 200 • Gilbert, AZ 85234
(480) 964-2908

PATIENT # _____

- | | |
|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> DR. WILSON | <input type="checkbox"/> DR. THOMAS |
| <input type="checkbox"/> DR. KELLER | <input type="checkbox"/> DR. MULLEN |
| <input type="checkbox"/> DR. SHARPE | <input type="checkbox"/> DR. KOOIMA |
| <input type="checkbox"/> DR. DINOWITZ | |

HISTORY AND PHYSICAL

Name		SEX		MARITAL STATUS				DATE OF BIRTH	AGE
		M	F	S	M	W	D	SEP	
REASON FOR VISIT, INCLUDE BODY PARTS (LEFT AND RIGHT)		ONSET OF ILLNESS OR INJURY			HOW DID INJURY OCCUR? USE REVERSE OF SHEET IF NECESSARY.				
NAME OF PRIMARY CARE PHYSICIAN(S)		REFERRED BY			CURRENT JOB				
WERE YOU INJURED ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS AN AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF ATTORNEY			ATTORNEY PHONE		
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHERE WERE X-RAYS TAKEN (HOSPITAL, ETC.)			DATE X-RAYS TAKEN				

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

ALLERGIES & REACTIONS TO MEDICATIONS

CURRENT MEDICATIONS (Include over the counter)

SIGNIFICANT FAMILY HISTORY

INCLUDE: HEART DISEASE, BLEEDING DISORDERS, CANCER, DIABETES, MENTAL ILLNESS, ARTHRITIS, ETC. . .

REVIEW OF SYSTEMS

ARE YOU CURRENTLY OR HAVE YOU HAD PROBLEMS WITH: PLEASE CIRCLE NO OR YES

EYES	N Y	HIGH BLOOD PRESSURE	N Y	BLADDER PROBLEMS	N Y	HISTORY INFECTIONS	N Y
EAR, NOSE/THROAT	N Y	BLOOD CLOTS	N Y	THYROID PROBLEMS	N Y	CANCER	N Y
LUNGS OR BREATHING	N Y	BLEEDING PROBLEMS	N Y	BALANCE PROBLEMS	N Y	DIABETES	N Y
CHEST PAIN	N Y	DIGESTION/BOWEL PROBLEMS	N Y	BLACK OUTS/FAINTING	N Y	WEIGHT LOSS	N Y
IRREGULAR HEART BEAT	N Y	ARTHRITIS GOUT	N Y	PSYCHOLOGICAL PROB.	N Y	ULCERS	N Y

IF ANY YES, PLEASE DESCRIBE _____

HOW LONG HAVE YOU SMOKED _____ HOW MANY PACKS OF CIGARETTES PER DAY? _____ WEIGHT _____ HEIGHT _____

DO YOU LIKE YOUR PRESENT JOB? N Y DO YOU DRINK ALCOHOL? N Y TYPE AND HOW MUCH _____

RECREATIONAL DRUGS? N Y COFFEE/CAFFEINES? N Y

PATIENT SIGNATURE _____ DATE _____

Physical Exam

Ht

wt.

bp

pr

General appearance

eyes

ears

neck

breasts

heart

lungs

chest

abdomen

genitalia

blood vessels

rectal

neuro

extremities