KLASINSKI CLINIC

ORTHOPAEDICS
SPORTS MEDICINE

James M. Banovetz, MD PhD
Thomas R. Guse, MD
David M. Henneghan, MD
Cody A. Nikolai, MD
Matthew T. Riordan, MD

Kimberly Brown, PA-C
Tracie A. Hinaus, PA-C
James W. Lepak, PA-C
Kari A. Zdroik, PA-C

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HEALTH INFORMATION

Date _____/_____/_____

Name_____ Age_____ DOB _____/_____/_____ Sex M F

Referring Physician_____ Primary Care Physician_____

Are you a: ☐Recreational Athlete ☐ Competitive Athlete Team/Sport_____

Is this a: ☐ Work related injury DOI: _____ Employer: _____

Occupation_____

Marital Status: ☐ Married ☐Divorced ☐Single ☐Widowed Number of children _____

Education Level: ☐Grade school ☐High School ☐College Degree ☐Graduate School

Do you currently smoke? **N** or ___packs/day Have you ever smoked? **Y N** Chew tobacco? **Y N**

Drink Alcohol? **N** or ___drinks/day Use performance aids or recreational drugs? **Y N**

What are you being seen for today? _____

Have you had previous work-up for this problem?

MRI	**Y**	Injection	**Y**	Surgery	**Y**
CT	**Y**	Nerve Study	**Y**	X-Rays	**Y**
Bone Scan	**Y**	Physical Therapy	**Y**	Chiropractic	**Y**
Details:					

Have you had a Bone Density Study? **Y N** Where & When _____

Patient Medical History

Diabetes	**Y N**		Thyroid Problem	**Y N**		Heart Attack	**Y N**
Arthritis	**Y N**		Rheumatoid Arthritis	**Y N**		Coronary Artery Disease	**Y N**
Lupus	**Y N**		Lyme Disease	**Y N**		High Blood Pressure	**Y N**
Gout	**Y N**		Pseudo Gout	**Y N**		Stroke	**Y N**
Bleeding Problems	**Y N**		Dental Infection	**Y N**		Asthma	**Y N**
Stomach Ulcers	**Y N**		Heart Murmur	**Y N**		Lung Problems	**Y N**
Blood Clots	**Y N**		Osteoporosis	**Y N**		Cancer	**Y N**
Anesthetic Problems	**Y N**		MRSA	**Y N**		High Cholesterol	**Y N**
Depression	**Y N**		Alcohol Dependence	**Y N**		Sleep Apnea	**Y N**
Atherosclerosis	**Y N**		Anxiety	**Y N**		HIV Infection	**Y N**
			Skin Problems	**Y N**		**None of the Above**	☐

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Past surgeries _____

Are you taking any type of blood thinner, such as aspirin, Advil, Plavix, Coumadin? **Y N**

Are you experiencing any of the following?

Fever	**Y N**	Tingling	**Y N**	Bloody Stools	**Y N**
Chills	**Y N**	Rashes	**Y N**	Black Stools	**Y N**
Night Sweats	**Y N**	Chest Pain	**Y N**	Easy Bruising	**Y N**
Unexpected Weight Loss	**Y N**	Shortness of Breath	**Y N**	Easy Bleeding	**Y N**
Numbness	**Y N**	Belly Pain	**Y N**	Heartburn / Reflux	**Y N**
Headache	**Y N**	Cough	**Y N**	Runny Nose	**Y N**
Nasal Congestion	**Y N**	Nausea	**Y N**	Pain/Burning with Urination	**Y N**
Vomiting	**Y N**	Diarrhea	**Y N**	**None of the Above**	☐

Allergies ☐ **None**_____

Medications/Supplements/Vitamins

Name of Drug	Dose	Frequency

Use additional pages or attach a drug list if necessary

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Family Medical History

	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)
Diabetes	☐	☐	☐	☐	☐	☐
Thyroid Problem	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
Pseudo Gout	☐	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐
Anesthetic Problems	☐	☐	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐	☐	☐
Atherosclerosis	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐
Coronary Artery	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Lung Problems	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Skin Problems	☐	☐	☐	☐	☐	☐

Patient Signature _____ **Date** _____