Please fill out all spaces, highlighted is required.

ALL SPORTS ORTHOPEDICS

"Keep You In The Game"

Dr. Thomas McWeeney, MD

Phone: 503-506-8384

First Name ________________________________ Last Name ________________________________

DOB __________________________ SSN ________________________________

Address ____

City __________________________ State _____________________ Zip Code_____________________

Phone ____ Alternative Phone _______________________

Employed ___________________________________ Employer ________________________________

Email Address____ Marital Status______________

Spouse Name _____________________________________ Phone Number_______________________

Emergency Contact __________________________________Phone Number ______________________

Ethnicity ____________________ Race ________________

Dominant Hand Right Left

Height_________________________ Weight ________________________________

Smoker YES NO Alcohol Consumption YES NO Drug Use _______________________

Primary Care ___________________________________ Clinic Name ___________________________

Phone Number _______________________________

Referring Doctor ________________________________

Pharmacy _____________________ Location _______________________ Phone __________________

Was this a work injury? ________________ When ___________________Where ___________________

Insurance Information

Insurance Name ______________________________ Member ID _____________________________

Group Number ____________ Subscriber _______________________ Subscriber DOB _____________

Secondary _________________________________ Member ID _________________________________

Group Number ________________________________

History of Present Illness

Location of Pain___________________________________ Right Left

Why are we seeing you today? ____

Severity of Pain Mild Moderate Severe How long _____________________________

When does the pain occur most? ________________________ How Often ______________________

What caused the pain_____________________________________ Injury _________________________

Have you previously experienced any injury of symptoms regarding this body part? Yes No

If yes explain____

Please list any hobbies or sports that you enjoy ____

What actives are you unable to perform due to pain? ____

Past Medical History

Please circle all that apply

MRSA	A-Fib	Anemia
Angina	Anxiety	Arthritis
Asthma	Back Trouble	Bi-Polar
Bleeding Disorder	Blood Clot –DVT-PE	Bronchitis
Cancer Type _________________	Chest Pain	CHF
Depression	Diabetes	Dialysis
Diverticulitis	Emphysema	Epilepsy/Seizures
GI-Bleed-Reflux	Glaucoma	Heart Attack
Heart Murmur	Hepatitis	High Blood Pressure
High Cholesterol	HIV	Irregular Heart Beat
Liver Problems	Migraines/Headaches	Neurological Disorders
Numbness/Tingling	Pace Maker	Pneumonia
Rheumatoid Arthritis	Sleep Apnea	Stroke
Thyroid Hyper/Hypo	Tuberculosis	Other

Past Surgical History (continued on next page)

Abdominal Surgery	ACL Repair	Adenoidectomy
Amputation	Appendectomy	Aortic Valve Replacement
Arthroscopic Hip Surgery	Arthroscopic Knee Surgery	Arthroscopic Shoulder Surgery
Back Surgery	Carpal Tunnel	Colon Resection
Foot Surgery	Gastric Bypass	Heart Bypass Surgery
Heart Valve Replacement	Hip Fracture & Surgery	Hysterectomy
Joint Fusion	Leg Circulation Surgery	Total Knee
Pace Maker	Rotator Cuff Repair	Sinus Surgery

Shoulder Surgery	Thyroid	Tonsillectomy
Total Ankle Replacement	Total Knee Replacement	Total Hip Replacement
Total Shoulder Replacement	Weight Loss Surgery	Other

Family Medical History that is related to injury

Please circle all that apply

Anxiety	Back Trouble
Bleeding Disorder	Chest Pain
Cancer Type ___________________	Diabetes
Numbness/Tingling	Migraines/Headaches
Other	Pace Maker

Medication List

Name Of Medication	Dose:

Allergies

Allergy	Reaction

I attest that the information I have given here is correct and true to the best of my knowledge. I also hereby assign benefits to be paid directly to the doctor, and authorize him to furnish information regarding my injury to my insurance carrier. I understand that I am responsible for any amount of not paid amount by my insurance.

Signature____ Date ________________________________