

# GOTHAM CITY ORTHOPEDICS, LLC

SEAN LAGER, M.D.

Patient's Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Date: \_\_\_\_\_ Physician's #: \_\_\_\_\_

**General Medical Information (answering all questions will help us to be appraised of your general health status)**

Did the patient bring someone on this visit? \_\_\_\_\_ If yes, relationship to the patient: \_\_\_\_\_

Please list any medication you are allergic to: \_\_\_\_\_

**Please list current medication:**

\_\_\_\_\_  
 \_\_\_\_\_

**List all surgical procedures and any hospitalizations in your lifetime:**

	Year	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Past Medical Illnesses (Check the ones you have had)**

Acid	Diabetes	High blood pressure	Strokes
Anemia	Epilepsy	Kidney/Bladder Infection	Thyroid Disorder
Arthritis	Gallbladder	Kidney Stones	Tuberculosis
Asthma	Gout	Phlebitis	Ulcers
Blood clotting disorder	Heart Attack	Poor Circulation	
Cancer	Heart Disease	Sickle Cell Anemia	
Chronic Bronchitis	Hepatitis		

Other: \_\_\_\_\_

**Social History:**

Do you have any children? \_\_\_\_\_ If yes, how many? \_\_\_\_\_

Do you live alone? \_\_\_\_\_

Do you currently smoke? \_\_\_\_\_ Amount: \_\_\_\_\_ pack(s) a day for \_\_\_\_\_ year(s)

How much alcohol do you drink? (please circle)    None    Occasional    1-2 drinks a day    More

**Work History: (please circle)**

Employed    Unemployed    Self-Employed    Student    Homemaker    Retired    Disabled

Other: \_\_\_\_\_

Company's Name: \_\_\_\_\_

Occupation/Work Description: \_\_\_\_\_

School's Name: \_\_\_\_\_

**Family History: (Please check all that apply in blood relatives)**

Blood clotting disorder    Diabetes    Stroke    Arthritis    Cancer

Heart Disease    Tuberculosis    Sickle Cell Anemia    Nervous Illness    Kidney Disease

If any of the above were checked please list relative(s) the illness applies to and any other medical conditions:

\_\_\_\_\_  
 \_\_\_\_\_

Do you have a regular family doctor? \_\_\_ No    \_\_\_ Yes

Physician's first and last name: \_\_\_\_\_

Physician's Address and/or telephone number: \_\_\_\_\_

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Relationship

\_\_\_\_\_  
 Date