

MEDICATIONS

Drug Name	Dose per day	Reason for medication
IF NONE CHECK HERE ()		

VITAMIN USE (Check all that apply): ___None___ Daily multi-vitamin___ Vitamin C___ Vitamin D
 ___ Iron___ Calcium___ Other (What type?)_____

Have you ever had general anesthesia? Yes___ No___
 Do you have any problems with anesthesia? Yes___ No___ Describe: _____

DO YOU HAVE ANY ALLERGIES? (Including medications) YES___ NO___
 If yes, please list everything that you are allergic to: _____

DO YOU HAVE A PACEMAKER? YES___ NO___
 Are all immunizations up to date? Yes___ No___
 If no, which immunizations are due? _____

FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status or Cause of Death
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

PATIENT SIGNATURE: _____ **DATE:** _____

If a Patient is a Minor:
 Parent's First & Last Name: _____
 Address & Phone (if different) _____
 Father's Employer Name & Phone: _____
 Mother's Employer Name & Phone: _____
 School Student Attends: _____

I give my permission to Boca Raton Orthopaedic Group, Inc. to administer medical treatment, including x-rays to my son/daughter.
 (MUST be signed by parent/guardian if child is under 18 years of age).

Signed X _____ **Relationship to patient:** _____

******For Office Use Only******

Reviewed By:	Date	Reviewed By:	Date