

AO Orthopedics, Inc.

Vincent R. Avallone Jr. D.O.

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Board Certified, Diplomates A.O.B.O.S.

Medical History

Name _____ DOB ____/____/____

SS# _____ Age _____ Height _____ Weight _____ Right or Left handed ? R__ /L__

Name of employer _____ Type of work _____

Marital Status: M / D / S / W Recreational / Sports Activities: _____

Family Physician _____ Referred By _____

Reason for Visit _____

How long have you had symptoms? _____ Is Injury Work Related? _____

Past Medical / Surgical History (please use back of page for additional explanation)

Current Medications: (If you have a list please ask receptionist to attach it to this form)

Drug name	Dose	How often	Drug name	Dose	How often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medication Allergies (please list all) _____

Have you had surgery or been hospitalized? Yes / No

Reason for Hospitalization _____

Have you ever received a blood transfusion? Yes / No When? _____

Indicate whether you have been treated for any of the following illnesses or conditions:

Cancer	Yes / No	Abnormal Chest x-ray	Yes / No
Stroke / TIA	Yes / No	Stomach / Bowel Disease	Yes / No
High Blood Pressure	Yes / No	Diabetes	Yes / No
Heart Disease	Yes / No	High Cholesterol	Yes / No
Skin Disease	Yes / No	Vein Trouble / Blood clots	Yes / No
Abnormal Bleeding	Yes / No	Joint Disease / Arthritis	Yes / No
Anemia / high / low white count	Yes / No	Lung Disease / Asthma	Yes / No
Reproductive or prostate probs	Yes / No	Anxiety, Deprssn Psych	Yes / No
Other _____			

Past or Current Risk Factors

Smoking: Yes / No Packs per day _____ Number or years _____ Years Stopped _____

Recreational Drug use: Yes / No in Past Yes / No _____

Alcohol use: Never / Occasional / Social / Moderate / Heavy:

Family History

TB	Yes / No	Cancer _____	Yes / No
Mental Health Disorders	Yes / No	High Blood Pressure	Yes / No
Kidney Disease	Yes / No	Heart Disease	Yes / No
Diabetes Mellitus	Yes / No	Thyroid Disease	Yes / No
Cerebral Vascular Accidents	Yes / No	Lung Disease	Yes / No
Vascular disease	Yes / No	Epilepsy	Yes / No
Cholesterol	Yes / No		

Additional Family History not listed above

Any additional concerns or problems you feel the Doctor should be made aware:

Signature _____

Date ____ / ____ / ____

(Patient / Parent or Legal Guardian)