

Avista Two Medical Plaza
Pavilion
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Orthopedic Professional Association

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Medical

1155 Alpine Street
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Patient name _____ Age _____ Date _____

Employer/School _____ Position/Grade _____

Problem

Current Problem?

Date this problem started _____

Is this work related? _____

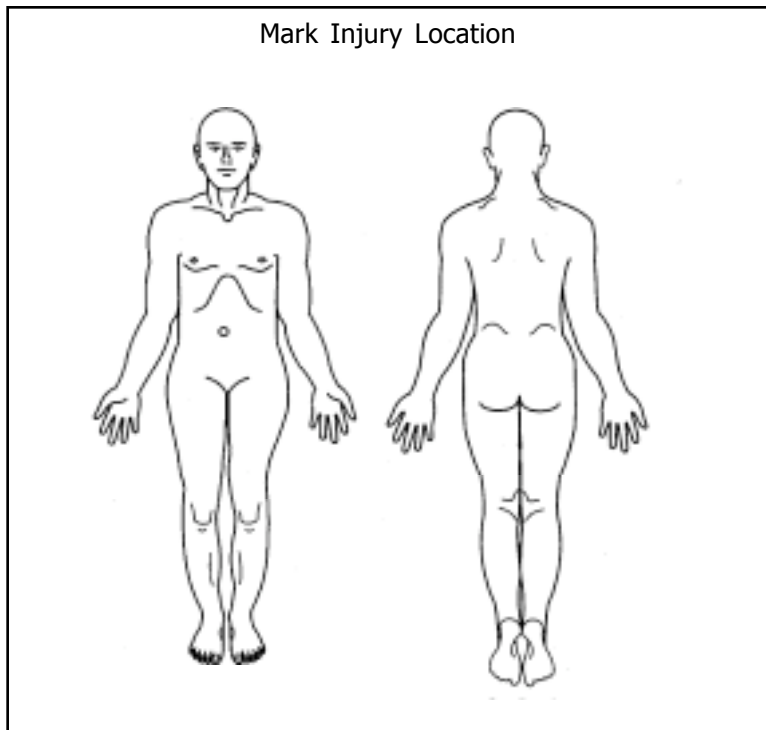
How did problem occur/start _____

Treatments you have received for this problem _____

Seen in ER?(if yes name) _____ X-Rays taken? _____

Auto Accident? _____ Pending litigation? _____

Who referred you to our office _____



PLEASE TURN OVER

Name _____ Date _____

Surgical History (any surgery, not just orthopedic surgery)

<u>Problem + Date or Age</u>	<u>Treatments + Doctor</u>	<u>Successful (Y/N)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Are you pregnant? _____

List any current or past medical problems (dates and Doctors)

Current Medications (Prescription, Over the Counter, Herbal health products, vitamins, or dietary supplements)

Name	Dose	Frequency	Name	Dose	Frequency
1. _____			7. _____		
2. _____			8. _____		
3. _____			9. _____		
4. _____			10. _____		
5. _____			11. _____		
6. _____			12. _____		

Allergies to MEDICATIONS (list medication and reaction)

How often do you smoke (per day) _____

How often do you drink (per week) _____

How often do you use recreational drugs (per week) _____

Family Physician _____