Arizona Orthopedic and Fracture Surgeons

Dr. Charles M Creasman MD

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

What are you seeing the doctor for today: _____ Affected side: Left Right

Date of injury or onset of problem: _____ Dominant Hand: Left Right

Work Related? Yes / No Auto Accident? Yes / No Attorney Involved? Yes / No

Have you had x-rays taken? Yes / No If yes, where? _____

Have you had an MRI? Yes / No If yes, where? _____

Pharmacy: _____ Pharmacy Cross street or address_____

Pharmacy Phone Number: _____

Drug Allergies: Yes / No Please list drug and reactions: _____

_____

Daily Medications: (please include pain meds, herbs, vitamins & OTC)

Name Dosage/Strength Times/day

_____

_____

_____

_____

Past Surgical History (list type and date)

_____

_____

_____

Past Medical/Hospital History (Illness/Condit ions):

_____

_____

_____

Do you smoke? Yes / No Packs per day:_____

For how many years? _____

Do you exercise? Yes / No How Often? _____

What type? Running, Biking, etc._____

Do you drink alcohol? Yes / No

If yes, average consumption a week? _____

What is your occupation? _____

Do you now or have you ever had:

Anemia	Yes	No
Diabetes	Yes	No
Cancer/Type	Yes	No
Kidney Trouble	Yes	No
Bladder Issues	Yes	No
High Blood Pressure	Yes	No
Heart Trouble	Yes	No
High Cholesterol	Yes	No
Asthma	Yes	No
Neurological Disorder/Seizures	Yes	No
Depression	Yes	No
Stroke	Yes	No
Thyroid Disorder	Yes	No
Ulcer /Stomach Problems	Yes	No
Hepatitis (Type)	Yes	No
Arthritis	Yes	No
Gout	Yes	No
Phlebitis /Blood Clots	Yes	No
AIDS/HIV	Yes	No
Substance Ab use	Yes	No
Fibromyalgia	Yes	No
Sleep Apnea	Yes	No

Family History:

Please list any major medical conditions & if they are

Deceased or alive:

Father: _____

Mother: _____

Siblings: _____

_____

_____

Is there any possibility you could be pregnant? Yes / No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? Yes / No

If yes, who and what is their age: _____

Have you or any blood relative, younger than 50, ever had a serious reaction to anesthesia? Yes / No

If yes, who and what is their age? _____

The above information is to the best of my knowledge, a true statement of my current condition.

Patient Signature: _____ Date: _____

Dr. Charles M Creasman MD

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone#: _____ Home Phone#: _____ Work Phone #: _____

Email: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Other: _____ Phone: _____

Date of Birth: _____ Gender: Male / Female Marital Status: _____

Social Security #: _____ Employer/School: _____

Employment Status: ☐ FT ☐ PT ☐ Not employed ☐ Self-employed ☐ Retired ☐ Student ☐ Active Duty

Emergency Contact: _____ Relationship: _____ Phone: _____

Federal Privacy Standards require the following information:

Race: _____ Ethnicity: _____ Primary Language: _____
(i.e. Caucasian/Hispanic/Asian) *(i.e. American/Mexican/German)*

How did you hear about us?

☐ Family Member ☐ Friend ☐ Internet ☐ School Athletic Trainer

☐ Another Physician (Name of Physician): _____ ☐ Other: _____

Responsible Party/Insured Party Information: (Please fill out completely if other than self)

Name: _____ Relationship: _____

Date of Birth: _____ SSN: _____ Gender: Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell#: _____Work#: _____

E-Mail: _____ Responsible/Insured Party's Employer_____

Insurance Information:

Primary Insurance: _____Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Policy ID# _____ Policy ID#: _____

Group #: _____ Group #: _____

Insurer's Address: _____ Insurer's Address: _____

If the primary policy holder is anyone other than you, please fill out the responsible Party/Insured Party Information above.

Signature: _____ Date: _____