Bay Street Orthopaedics
New Patient/Problem Office Visit Form

Patient Name:	**Referral Doctor:**
Date of Birth:	**Primary Care:**

Allergies:

Seeing a pain specialist:	☐ Yes	☐ No	
On pain contract:	☐ Yes	☐ No	If yes, by what doctor:

Past Medical History			**Past Surgical History**			**Medications-Name & Dosage**
Diabetes	☐ Yes	☐ No	___			___
Cancer	☐ Yes	☐ No	___			___
Blood Clots	☐ Yes	☐ No	___			___
Bleeding Disorder	☐ Yes	☐ No	___			___
Stroke	☐ Yes	☐ No	___			___
Heart Disease	☐ Yes	☐ No	___			___
High Blood Pressure	☐ Yes	☐ No	___			___
Rheumatoid Arthritis	☐ Yes	☐ No	___			___
Osteoarthritis	☐ Yes	☐ No	___			___
Gout	☐ Yes	☐ No	___			___
Ulcers	☐ Yes	☐ No	Pacemaker:	☐ Yes	☐ No	
Other:			Stent:	☐ Yes	☐ No	

Marital Status:	Hobbies:
Occupation:	Family Medical History:

Smoker:	☐ Yes	☐ No	packs/day	years ☐ former smoker ☐ never smoker
Alcohol:	☐ Yes	☐ No	Frequency:	

Signature: **Date:**