

ORTHOPEDIC GROUP OF BRIMINGHAM
DR. MARK A. ELKUS
NEW PROBLEM / UPDATE FORM

OFFICE USE ONLY

HEIGHT: _____

WEIGHT: _____

PULSE: _____

Date: _____

Chart # _____

Patient's Name: _____ DOB: _____

Is this a new problem you are being seen for today? ____ Yes ____ No

If yes, what is the new problem: _____

Is this a result of an: Work Related Accident ____ Yes ____ No

Automobile Accident ____ Yes ____ No

Other _____

Please explain: _____

Date of accident or injury: _____

Have you been treated for this problem? ____ Yes ____ No. If yes where: _____

How has problem been treated? _____

Has your medical history changed since your last visit? ____ Yes ____ No

If yes please explain: _____

What medications are you taking? (prescription and over the counter) _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you pregnant or trying to get pregnant? _____

Do you have allergies? _____

Do you have any body piercings or tattoos? ____ Yes ____ No. If yes, where? _____

Pharmacy Name, Phone and Zip: _____

Primary Care Doctor and Phone: _____

Patient Signature

*if minor, must be signed by parent or guardian

Date