Amer J Mirza, MD
Summit Orthopaedics, Lake Oswego
www.summitdocs.com

SUMMIT ORTHOPAEDICS

Patient Name: ____ Age: __________

Date of Birth: ____________________ Primary Care Physician: _______________________

Employer: _______________________ Occupation: _______________________________

Problem/Injury: ___________________________________ ☐Right ☐Left ☐Both sides

Date of Injury: ____________________ Where did this injury occur? _______________________

Describe how it happened: ____

____

Were you treated in the ER? ☐No ☐Yes Which hospital?: _________________________________

Have you previously been treated for this injury? ☐No ☐Yes Where?_________________________

Did another provider refer you to our office? ☐No ☐Yes Which provider?_____________________

Are you in pain today? ☐No ☐Yes If so, rate the pain from 1-10 with 10 being the highest level. ________

List all medical conditions: ____

____

Previous surgeries: ____

____

Medications currently taking: ____

Allergies to medications: ____

Preferred Pharmacy: ____

Additional questions or concerns in relation to this injury: ____________________________________

____