CORE ORTHOPEDICS & SPORTS MEDICINE

ANNUAL PATIENT ASSESSMENT UPDATE

PLEASE PRINT USING BLACK OR BLUE PEN ONLY

Patient's Legal Name: (Last)	(First)	(M.I.)
Who is your Medical Doctor or Primary Care Physician? Name: _____	Patient's Age:_____Years	Date of Birth: / /

The following are "new" medical conditions:

_____

_____

_____

Please provide an updated list of all current medications:

CURRENT MEDICATIONS *Please include prescription drugs, vitamins and drugs you buy over the counter.*

Medications	Dose/Strength	When do you take it?	

Allergies to Medicine: _____

_____

I have reviewed my initial "Patient Assessment" _____
Initials Date

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