

**Steven M. Madey, M.D.**  
**501 N. Graham Street, Suite 250**  
**Portland, OR 97227**  
**(503) 249-0719**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Problem/Injury: \_\_\_\_\_

Right: \_\_\_\_\_ Left: \_\_\_\_\_ Both: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Who referred you?: \_\_\_\_\_

Were you treated in the E.R.?: \_\_\_\_\_ Which hospital?: \_\_\_\_\_

Describe how your injury occurred: \_\_\_\_\_

---

---

---

---

---

List all medical conditions: \_\_\_\_\_

---

---

---

Previous surgeries: \_\_\_\_\_

---

---

Medications: \_\_\_\_\_

---

---

Allergies to medications: \_\_\_\_\_

---

---

Name of your family physician: \_\_\_\_\_