PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date_____/_____/_____ Date of last physical exam_____/_____/_____

Last Name_____ First Name_____ M.I._____

Social Security No._____ Date of birth_____/_____/_____ Height_____ Weight_____

Chief Complaint - what is the main reason for your visit today? *(Describe your problem in detail.)*

_____

_____

_____

History of Present Illness

Location of the problem? *(circle)*

Arm - L / R Back Ankle - L / R Hand - L / R
Hip - L / R Neck Leg - L / R Ribs - L / R

On a scale of 1-10, with 10 being the most severe, circle the number that best described the problem:

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago
Other_____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side
Other_____

How long does the problem last?

30 minutes 1 hour It is always there
Other_____

Is anything else occuring at this time? **Yes** **No**

Nasuea Rash Headaches
Other_____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there
Other_____

Does the problem interfere with you normal functions?

Yes No
If Yes, explain_____

Past Medical & Social History

When did you have your last: *(what year?)*

Papsmear_____ Heart exam_____ Breast exam_____

Circle all serious illnesses in your immediate family

Diabetes - Y / N Heart disease - Y / N
Tuberculosis - Y / N Asthma - Y / N
Cancer - Y / N Other_____

Circle all past personal past illnesses

Diabetes - Y / N - Y / N
Tuberculosis - Y / N Breathing problems - Y / N
Cancer - Y / N Circulatory problems - Y / N
Heart disease - Y / N Kidney problems - Y / N
Asthma - Y / N

Do you smoke? - Y / N If yes, how much?_____

Do you drink? - Y / N If yes, how much?_____

Are you allergic to Latex? - Y / N

Have you had any previous reactions to anesthesia - Y / N

PHYSICIAN USE ONLY *(comments/notes)*

Have you had any surgery in the last 5 years? - Y / N If yes, list

_____ _____
_____ _____
_____ _____

Are you on any medications? - Y / N If yes, list all

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you on a special diet? - Y / N If yes, please explain

_____

Do you have any food allergies? - Y / N If yes, list all

_____

Do you have any allergies? - Y / N If yes, list all

_____
_____
_____

Patient Signature_____ **Date**_____

Over ▶

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain and yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other_____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other_____		

Allergic Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other_____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other_____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other_____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other_____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other_____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistant itch	Y	N
Other_____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other_____		

Ear/Nose/Throat/Mouth

Ear infectionr	Y	N
Soar throat	Y	N
Sinus problems	Y	N
Other_____		

Genitourinary

Urine infection	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other_____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other_____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other_____		

Psychologic

Are you generally satisfied with your life.	Y	N
Do you feel severly depressed	Y	N
Have you considered suicide	Y	N
Other_____		

Patient Signature_____ **Date**_____

PHYSICIAN USE ONLY *(comments/notes)*

Physician Signature_____ **Date**_____

PLEASE ANSWER ALL QUESTIONS

TODAYS DATE: _____ DATE OF BIRTH: ____/____/____ SEX: M F

PATIENTS NAME: _____ PATIENTS AGE: _____

ADDRESS: _____ REASON FOR APPOINTMENT: _____

TOWN: _____ _____

ZIP CODE: _____ _____

TELEPHONE: HOME: _____ DATE SYMPTOMS STARTED: _____

TELEPHONE: WORK: _____ LEFT OR RIGHT: _____

SOCIAL SECURITY: _____ WERE X-RAYS TAKEN?: YES NO

IF UNDER 18, PARENTS NAME: WHERE?: _____

_____ DATE OF X-RAYS: _____

REFERRING DR.: _____ TELEPHONE NO.: _____

ADDRESS: _____

FAMILY DOCTOR: _____ TELEPHONE NO.: _____

INSURANCE INFORMATION

NAME OF *PRIMARY* INSURANCE

_____

ADDRESS OF INSURANCE COMPANY

_____

POLICY HOLDER: _____

SOCIAL SECURITY NO.: _____

DATE OF BIRTH: _____

NAME OF INSUREDS EMPLOYER

_____

POLICY NUMBER GROUP NUMBER

_____

RELATIONSHIP TO PATIENT

NAME OF *SECONDARY* INSURANCE

_____

ADDRESS OF INSURANCE COMPANY

_____

POLICY HOLDER: _____

SOCIAL SECURITY NO.: _____

DATE OF BIRTH: _____

NAME OF INSUREDS EMPLOYER

_____

POLICY NUMBER GROUP NUMBER

_____

RELATIONSHIP TO PATIENT

_____

INSURANCE PAYMENT ORDER

I authorize the release of any medical information necessary to process an insurance claim and authorize direct payment to ORTHOPAEDIC & SPORTS ASSOCIATES OF LONG ISLAND, P.C.. I understand that I am financially responsible for treatment rendered. (If insured is a minor, parent or guardian must sign).

LEGAL SIGNATURE: _____ DATE: _____

FORM: NPT