

GENESEE ORTHOPEDICS INFORMATION SHEET

NAME _____ DOB _____ AGE _____
REFERRING DOCTOR _____ PRIMARY DOCTOR _____
IS THIS A WORK-RELATED INJURY? _____ IF SO, DATE OF INJURY _____
IS THIS A NO-FAULT INJURY? _____ IF SO, DATE OF INJURY _____

WHAT ARE YOU HERE FOR TODAY? _____ WHICH SIDE? _____
RIGHT OR LEFT HANDED? _____
HOW LONG HAVE YOU HAD THIS PROBLEM? _____
HOW DID IT HAPPEN? _____
WHAT MAKES IT BETTER? _____
WHAT MAKES IT WORSE? _____
DESCRIBE THE PAIN(eg, burning, throbbing, sharp) _____
ANYTHING ELSE ASSOCIATED WITH THIS PROBLEM? _____

MEDICAL PROBLEMS

HIGH BLOOD PRESSURE	y n	HEART DISEASE	y n
LUNG DISEASE/ASTHMA	y n	KIDNEY DISEASE	y n
STROKE	y n	THYROID DISEASE	y n
DIABETES	y n	HEPATITIS	y n
RHEUMATOID DISEASE	y n	OSTEOARTHRITIS	y n
CANCER	y n	ANEMIA	y n

MEDICATIONS—PLEASE LIST OF ALL YOUR CURRENT MEDICATIONS AND SUPPLEMENTS AS WELL AS THE DOSAGES

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

ALLERGIES _____

PAST SURGICAL HISTORY WITH DATES PLEASE

SOCIAL HISTORY

DO YOU USE TOBACCO? _____ IF SO, HOW MUCH? _____
DO YOU USE ALCOHOL? _____ IF SO, HOW MUCH? _____
ARE YOU MARRIED? _____ ARE YOU PREGNANT? _____
ARE YOU WORKING? _____ OCCUPATION? _____

WHAT MEDICAL PROBLEMS RUN IN YOUR FAMILY?

PLEASE LIST ANY FRACTURES (broken bones) YOU HAVE HAD:

REVIEW OF SYSTEMS (circle yes or no)

Constitutional

Fever/Chills yes no
Weight changes yes no
Dizziness yes no

Eyes

Glasses/contacts yes no
Cataracts yes no
Decrease vision yes no

Ear/Nose/Throat

Hearing problems yes no
Sinus problems yes no

Heart

Chest pain yes no
Palpitations yes no
Poor circulation yes no

Lungs

Shortness of breath y n
Cough yes no
Asthma yes no

Gastrointestinal

Stomach Ulcers yes no
Heartburn yes no
Diarrhea yes no

Genitourinary

Blood in urine yes no
Bladder infections yes no
Incontinence yes no

Musculoskeletal

Joint pain yes no
Joint swelling yes no

Neurological

Frequent headaches yes no
Paralysis yes no
Weakness yes no

Skin

Rash yes no
Psoriasis yes no
Eczema yes no

Psychiatric

Depression yes no
Bipolar disease yes no

Endocrine

Thyroid disease yes no
Diabetes yes no

Blood

Bleeding problems y n
Easy bruising? Yes no
Blood clots? Yes no

Immunologic

Allergies to foods y n
Immune disorder y n

Other
