PLEASE PRINT

GENESEE ORTHOPEDIC AND HAND SURGERY ASSOCIATES, P.C.

Today's Date: ____/____/___

____ ____/____/____ Age:________ Sex: Male / Female
Name (Last, First MI) Date of Birth

Were you referred by this Dr.? YES OR NO
____ or someone else? ________________________________
Primary Care Physician/Family Dr. Person's name

May we share information with: Primary Care Physician? YES OR NO Referral person? YES OR NO

Which pharmacy do you use? ____

Problem you are here for today: ____

____

____

WORK RELATED INJURY: YES OR NO NO FAULT INJURY: YES OR NO

MEDICATIONS

Please list all medications, including dietary supplements, you are taking:

	Name	Dosage
1.	________________________	____________________
2.	________________________	____________________
3.	________________________	____________________
4.	________________________	____________________
5.	________________________	____________________
6.	________________________	____________________
7.	________________________	____________________
8.	________________________	____________________
9.	________________________	____________________
10.	________________________	____________________

SOCIAL HISTORY

Do you use?

Tobacco	Yes	No
Alcohol	Yes	No
Other Substances	Yes	No
Are you married?	Yes	No
Are you pregnant?	Yes	No
Are you working?	Yes	No

Occupation: ____________________________________

FAMILY HISTORY

Father: Living? Yes No
Medical History: ______________________________

Mother: Living? Yes No
Medical History: ______________________________

PAST MEDICAL HISTORY

Have you had any medical problems?

HIV/AIDS	YES	NO
ARTHRITIS	YES	NO
CANCER	YES	NO
If yes, type: ________________________________		
DIABETES	YES	NO
HEART DISEASE	YES	NO
HEPATITIS (A) (B) (C) (D)	YES	NO
HIGH BLOOD PRESSURE	YES	NO
HIGH CHOLESTEROL	YES	NO
KIDNEY DISEASE	YES	NO
LUNG DISEASE/ASTHMA	YES	NO
RHEUMATIC/SCARLET FEVER	YES	NO
STROKE	YES	NO
THYROID DISEASE	YES	NO

ALLERGIES

List all allergies (medications and other substances):

____

____

____

PAST SURGICAL HISTORY

Please list all operations you have had: ____________________

____

____

____

FRACTURE HISTORY

Please list all bones you have broken: ____________________

____

____

Please turn over

REVIEW OF SYSTEMS

Do you have any of these symptoms? **Please circle Yes or No for each condition.**

Constitutional

Fever / Chills Yes No
Weight Change Yes No
Please specify: Loss or Gain
Dizziness Yes No

Eyes

Glass / Contacts Yes No
Cataracts Yes No
Decreased Vision Yes No

Ear, Nose, and 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 Yes No
Cough Yes No
Asthma Yes No
Pulmonary Embolism Yes No

Gastrointestinal

Stomach Ulcers Yes No
Reflux Disease (Heartburn) Yes No
Diarrhea Yes No

Genitourinary

Blood in Urine Yes No
Bladder Infection Yes No
Do you leak urine? Yes No
Get up at night to urinate? Yes No

Musculoskeletal

Joint Pain Yes No
Joint Swelling Yes No

Neurological

Frequent Headaches Yes No
Paralysis or Weakness Yes No

Skin

Rash or Psoriasis Yes No
Dry Skin or Eczema Yes No

Psychiatric

Depression Yes No
Bipolar Disease Yes No

Blood

Bleeding Problems Yes No
Bruise Easily Yes No
Previous Blood Transfusion Yes No
Previous DVT Yes No

Immune System (Allergies)

Allergies to foods or to things other than medicines: Yes No
What: ______________________________
____

Other Problems:

____
____
____

Height: _______ Weight: _________

For office use only: