[web version]

Montefiore

Orthopedic Surgery First-Time Office Visit

YOUR BASIC INFORMATION:

Name:_____ Age: _____ Date of Birth: _____

Primary care doctor: _____ Today's Date:_____

Did anyone refer you to us? ☐ No ☐ Yes, my primary care doctor Height: _____

☐ Someone else [Please list: _____] Weight: _____

REASON YOU ARE HERE TODAY:

What is the problem or injury?_____

When did the problem start? _____ How severe is the pain? (1-10 scale) _____

Is this a work-related injury? ☐ Yes ☐ No Is this injury from a motor vehicle accident? ☐ Yes ☐ No

ALLERGIES: ☐ **NONE** ☐ Latex ☐ Penicillin ☐ Aspirin ☐ Iodine ☐ Shellfish ☐ Other:_____

MEDICATIONS YOU TAKE: _____

_____

OPERATIONS/SURGERY YOU HAVE HAD: _____

_____

MEDICAL HISTORY: (Check any health problems that you have or have had, write any that are not listed)

☐ Bleeding problems
☐ Anemia
☐ High blood pressure
☐ Heart disease/heart attack
☐ Atrial Fibrillation
☐ Pacemaker
☐ Lung disease
☐ COPD/emphysema
☐ Kidney disease
☐ Liver disease
☐ Hepatitis [☐ A ☐ B ☐ C]
☐ Colitis
☐ Diverticulitis
☐ Ulcers/GERD
☐ Thyroid problems
☐ Lupus
☐ Arthritis
☐ Gout
☐ Parkinson's
☐ Stroke/TIA
☐ Seizures
☐ Phlebitis/DVT (blood clot)
☐ Venereal disease
☐ Cancer [Type: _____]
☐ Asthma
☐ Diabetes
☐ HIV or AIDS
☐ High Cholesterol
☐ Other: _____

HOW ARE YOU FEELING TODAY?: (Check any symptoms that you have today, write any that are not listed)

☐ Weight gain
☐ Weight loss
☐ Headaches
☐ Blackouts
☐ Dizziness
☐ Double vision
☐ Chest pain
☐ Shortness of breath
☐ Palpitations
☐ Cough
☐ Abdominal pain
☐ Bloody stool
☐ Joint pain
☐ Weakness
☐ Paralysis
☐ Low back pain
☐ Painful urination
☐ Bloody urine
☐ Urinary infections
☐ Rashes
☐ Lumps
☐ Other: _____

MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY:

☐ Diabetes ☐ Heart disease ☐ High blood pressure ☐ Arthritis ☐ Other: _____

PERSONAL HISTORY:

What kind of work do you do? _____ ☐ Retired ☐ Disability ☐ Unemployed

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living situation: ☐ Alone ☐ w/Spouse ☐ w/Family ☐ w/Significant other ☐ Other

Smoking: ☐ Most/every day ☐ Some days ☐ Former smoker ☐ Never smoked

If yes, how much?_____ For how many years?_____

Do you drink any alcohol? ☐ Never ☐ Occasional ☐ Frequent

Do you use any other drugs? ☐ None ☐ _____

REVIEWING PHYSICIAN PRINT NAME	SIGNATURE/CREDENTIALS	DATE/TIME