

GENESEE ORTHOPEDICS AND PLASTIC SURGERY ASSOCIATES, P.C.

“PLEASE PRINT”

Last Name: _____ First Name: _____ _____, _____	TODAY’S DATE: ____/____/_____ DOB ____/____/____ Age: _____ Sex: M / F
Primary Care Physician/Family Dr. _____	Were you referred by this Dr.? <input type="checkbox"/> Yes <input type="checkbox"/> No Or someone else? _____

Which pharmacy do you use? _____

Problem you are here for today: _____

PAIN LEVEL TODAY: (circle) 1 2 3 4 5 6 7 8 9 10

WORK RELATED INJURY: Yes No

NO-FAULT INJURY: Yes No

MEDICATIONS	
Please list all medications, including dietary supplements you are taking:	
<u>Medication</u>	<u>Dosage</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____

PAST MEDICAL HISTORY
Have you had any of the following medical problems? Please circle specific type for each condition.
ANESTHESIA COMPLICATIONS IF SO, WHAT? <input type="checkbox"/> Yes <input type="checkbox"/> No
ARTHRITIS : Osteo / Rheumatoid <input type="checkbox"/> Yes <input type="checkbox"/> No
CANCER If yes, type: <input type="checkbox"/> Yes <input type="checkbox"/> No
DIABETES: Type I / Type II <input type="checkbox"/> Yes <input type="checkbox"/> No
DVT/BLOOD CLOT <input type="checkbox"/> Yes <input type="checkbox"/> No
HEART DISEASE / ATTACK (MI) : DATE: / / <input type="checkbox"/> Yes <input type="checkbox"/> No
HEPATITIS: (A) (B) (C) (D) <input type="checkbox"/> Yes <input type="checkbox"/> No
HIGH BLOOD PRESSURE <input type="checkbox"/> Yes <input type="checkbox"/> No
HIGH CHOLESTEROL <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV / AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No
KIDNEY DISEASE <input type="checkbox"/> Yes <input type="checkbox"/> No
LUNG DISEASE / ASTHMA <input type="checkbox"/> Yes <input type="checkbox"/> No
MULTIPLE SCLEROSIS <input type="checkbox"/> Yes <input type="checkbox"/> No
RHEUMATIC / SCARLET FEVER <input type="checkbox"/> Yes <input type="checkbox"/> No
SLEEP APNEA <input type="checkbox"/> Yes <input type="checkbox"/> No
STROKE: Ischemic / Hemorrhagic / TIA <input type="checkbox"/> Yes <input type="checkbox"/> No
THYROID DISEASE <input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER: <input type="checkbox"/> Yes <input type="checkbox"/> No

ALLERGIES
List all allergies (medications and other substances) and reaction: _____ _____
PAST SURGICAL HISTORY
List all operations you have had and when: _____ _____
FRACTURE HISTORY
List all bones you have broken and when: _____ _____

SOCIAL HISTORY
Do you use tobacco/nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> cigarettes/cigars <input type="checkbox"/> chewing tobacco <input type="checkbox"/> E-cig/vaping
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Substances <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status: <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No
Occupation: _____
Hand Dominance: <input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed

PLEASE TURN OVER TO COMPLETE FORM ►

FAMILY HISTORY

FATHER: Living? Yes No

Medical History:

MOTHER: Living? Yes No

Medical History:

REVIEW OF SYSTEMS

Do you currently have any of these symptoms?

<u>CONSTITUTIONAL</u>	
Fever/Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Change? Loss / Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>EYES</u>	
Glasses / Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>EARS, NOSE, THROAT</u>	
Hearing Problems/loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>HEART</u>	
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Poor Circulation	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>LUNGS</u>	
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pulmonary Embolism	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>GASTROINTESTINAL</u>	
Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reflux Disease (Heartburn)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>GENITOURINARY</u>	
Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinary Incontinence (Do you leak urine?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nocturia (Get up at night to urinate?)	<input type="checkbox"/> Yes <input type="checkbox"/> No

<u>MUSCULOSKELETAL</u>	
Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>NEUROLOGICAL</u>	
Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paralysis or Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>SKIN</u>	
Rash or Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Skin or Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>PSYCHIATRIC</u>	
Depression or Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bipolar Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>HEMATOLOGIC</u>	
Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
DVT / Blood Clot	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>IMMUNE SYSTEM (ALLERGIES)</u>	
Allergies to foods or things other than medicine.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, what:	
Other Problems:	

VITALS (Taken Today):

BLOOD PRESSURE: _____/_____

PULSE: _____

CURRENT HEIGHT: _____ **WEIGHT:** _____

I give permission for G.O.P.S.A to release any Out of Work/Out of School notes or Return to Work/Return to School notes to my employer or school nurse listed below. This authorization pertains **ONLY** to the above listed documents.



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WORK RELATED INJURY: Yes No

NO-FAULT INJURY: Yes No

Patient Signature: _____

Employer/School: _____