

**GENESEE ORTHOPAEDICS AND SPORTS MEDICINE, LLP
MEDICAL HISTORY**

NAME: _____ DATE OF BIRTH: _____

Why are you seeing the Doctor or Physician Assistant today? _____

What body part is to be examined? _____ Left Right Both

When did your present condition begin? (date of injury) _____

Current problem is a result of (check all that apply): Car Accident Sports Related

Work Injury: How did it occur? _____ Other _____

I was doing the following when the condition began (check all that apply):

- Lifting Pulling Pushing Twisting Falling Bending Reaching
 Squatting Sports Suddenly Gradually Hit by Object Not Known

Current Medications: Or attach a copy of your own list or printout from your Pharmacist

Medication	Dose	How Often & How Long?

Allergies:

Type	No	Yes – Include name and reaction
Medications		
Latex		
Metal (example Nickel)		
Food		
Environmental		

Review of Systems:

Are you currently having or have you had problems with (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever/Chill/Night Sweats | <input type="checkbox"/> Digestion | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Gastritis/Ulcers | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Blackout/Fainting |
| <input type="checkbox"/> DVT | <input type="checkbox"/> Pregnant or chance of Pregnancy | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Lungs, Breathing | <input type="checkbox"/> Gout | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> TB | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Bleeding Problems/Transfusions |
| | <input type="checkbox"/> Cancer | <input type="checkbox"/> None of the above |

Briefly describe any items checked:

NAME: _____

DATE OF BIRTH: _____

Past Medical History:

Surgeries/Hospitalizations/Injuries/Illnesses	Year

Have you ever had general anesthesia (or put under for surgery)? No Yes
 If yes, have you had any problems with anesthesia? No Yes, Describe: _____

Do you use an assistive device? No Yes (check all that apply) Cane Walker Wheelchair

How tall are you? _____ How much do you weigh? _____

Family History:

Member	Alive/Deceased	Age	Health Status or Cause of Death
Father	A/D		
Mother	A/D		
Sister/Brother	A/D		
Sister/Brother	A/D		
Sister/Brother	A/D		

Do you have a family history of bleeding problems? No Yes
 Do you have a family history of anesthetic problems? No Yes

Social History:

Occupation: _____ Are you currently working? No Yes

Are you: Right-Handed or Left-Handed?

Are you currently a smoker: No Yes: _____ packs per day _____ years
 Were you previously a smoker: No Yes: _____ packs per day _____ years

Do you drink alcohol: No Yes: Daily Occasionally Rarely

Do you have a history of substance abuse: No Yes: Substance _____

Patient (or Parent/Guardian) Signature _____ Date _____