Orthopedic Associates of Long Island, LLP

Initial Visit History Form

Name:_____ Date:_____ Social Sec. #:_____

Phone: _____ Age: _____ DOB: _____ Sex: M / F

Name of your Primary Care Doctor: _____

Were you referred by a physician? **Y / N** : Name:_____ Phone: _____

Reason for today's visit: (briefly state history of problem and when symptoms began) _____

_____

_____

Problem due to: (check) __ car accident __ work-related __ school injury __ other

Past Medical History: Have you ever had any of the following medical problems?

Yes	No		Yes	No		Yes	No	
___	___	Stroke	___	___	Cancer	___	___	Thyroid Disease
___	___	Ulcers	___	___	Hepatitis	___	___	Rheumatoid arthritis
___	___	Colitis	___	___	Diabetes	___	___	High Blood Pressure
___	___	Asthma	___	___	Tuberculosis	___	___	Nervous Disorder
___	___	Lyme Disease	___	___	Heart Disease	___	___	Bleeding Disorders
___	___	Arthritis	___	___	Kidney Stones	___	___	Endocrine problems

Explain any positive responses above (and other medical problems not listed):_____

_____

_____

Past Surgical History: (list all surgeries) _____

_____

Medications (list): _____

_____

_____

Allergies (medicines): _____

Review of Systems: Are you having problems with any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Eyes	___	___	Psychiatric problems	___	___	Digestion/Bowel Movement
___	___	Ears, Nose, Throat	___	___	Joint pain	___	___	Stomach burning
___	___	Lungs/breathing	___	___	Immune system	___	___	Cardiovascular problems
___	___	Recent weight loss	___	___	Urinary problems	___	___	Hematologic / bleeding problems
___	___	Weakness/fatigue	___	___	Chest pain	___	___	Neurologic problems

Explain positive responses: _____

_____

Family Medical History: List medical problems of your relatives (ex. diabetes,cancer):

Grandparents:_____

Mother:_____ Father: _____

Siblings: _____

Children:_____

Social History: Occupation-_____ Working now? **Yes / No / Retired**

Do you **smoke**: **Yes / No /Quit**? Packs per day: ____ If quit, years smoked: ____yrs.

Alcohol use(circle one): Never / Occasional / Daily / Heavy / History of alcoholism

Any history of **Drug use** (list): _____

(circle one) Married / Single/ Divorced / Widowed Live alone? yes /no

Are you on a special diet? _____

Do you exercise / play sports (describe briefly)?_____

Completed by:(sign)_____ Reviewed by: **Dr.** _____

Do not write here ---------- Height: _____ **Weight:** _____ **Temp:** _____

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