SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

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Carmel, NY 10512
(845) 278-8400

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Newburgh, NY 12550
(845) 565-1454

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(914) 666-5550

Confidential

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME ______________________________

DATE OF BIRTH ____________ AGE ________ SEX ______ HEIGHT: _____ ft _____ inches WEIGHT: _____ lbs

MUST STATE - REASON FOR VISIT ______________________________

PRIMARY PHYSICIAN: ______________________________
Name **Address** **Phone number**

REFERRING PHYSICIAN ______________________________
Name **Address** **Phone number**

Is your injury work related (Workers Comp)? ☐ No ☐ Yes
Is your injury from an automobile accident (No Fault)? ☐ No ☐ Yes

ILLNESSES

Please Check All Answers - whether "Yes" or "No"

Do you have any of the following illnesses?

Illness	No	Yes	Illness	No	Yes	Illness	No	Yes
Heart Disease	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	Liver Disease, Hepatitis	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes
Blood Clots	☐ No	☐ Yes	Gall Bladder Disease	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Blood Circulation Problems	☐ No	☐ Yes	Stomach Problems, Ulcer	☐ No	☐ Yes	Rheumatoid Arthritis	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes	Enlarged Prostate	☐ No	☐ Yes	Lupus	☐ No	☐ Yes
Bleeding Tendencies	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Lyme Disease	☐ No	☐ Yes
Anemia	☐ No	☐ Yes	Hypoglycemia	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes
Asthma	☐ No	☐ Yes	Cancer, Tumor, Masses	☐ No	☐ Yes	Cataracts	☐ No	☐ Yes
Bronchitis	☐ No	☐ Yes	HIV / AIDS	☐ No	☐ Yes	Infection	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Eczema, Hives, Rashes	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes	Depression	☐ No	☐ Yes	Other	☐ No	☐ Yes

SURGERIES: Please list the Type(s) and Date(s) of any Past Surgeries IF NONE, CHECK BOX ☐

TYPE	DATE	HOSPITAL

CURRENT MEDICATIONS

(PRESCRIPTION, NON-PRESCRIPTION, HOMEOPATHIC, VITAMINS, NUTRITIONAL SUPPLEMENTS)

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____
____
____
____

ALLERGIES / SENSITIVITIES

(MEDICATIONS / FOODS / ADHESIVE TAPE / LATEX / METAL ALLERGY / OTHER) IF NONE, CHECK BOX ☐

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