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

664 Stoneleigh Ave., Ste. 300
Carmel, NY 10512
(845) 278-8400

667 Stoneleigh Ave., Ste. 116
Carmel, NY 10512
(845) 230-5178

400 Westage Bus. Ctr. Dr. Ste. 106
Fishkill, NY 12524
(845) 227-2228

657 E. Main St., Ste. 3
Mt. Kisco, NY 10549
(914) 666-5550

2 Victory Court
Newburgh, NY 12550
(845) 565-1454

Confidential

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME _____

DATE OF BIRTH_____ AGE _____ SEX _____ HEIGHT:_____ ft ____ inches WEIGHT: ____ lbs

MUST STATE - REASON FOR VISIT :_____

PRIMARY PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

ADDRESS: _____ **ADDRESS:** _____

TELEPHONE: _____ **TELEPHONE:** _____

IS YOUR INJURY WORK RELATED (Workers Comp.) YES / NO THE RESULT OF AN AUTOMOBILE ACCIDENT (No Fault) YES / NO

Do you have any of the following illnesses?

Heart Disease	☐ No	☐ Yes	Pneumonia	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes
Blood Clots	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Blood Circulation Problems	☐ No	☐ Yes	Liver Disease, Hepatitis	☐ No	☐ Yes	Rheumatoid Arthritis	☐ No	☐ Yes
Deep Vein Thrombosis	☐ No	☐ Yes	Gall Bladder Disease	☐ No	☐ Yes	Lupus	☐ No	☐ Yes
Pulmonary Embolism	☐ No	☐ Yes	Stomach Problems, Ulcer	☐ No	☐ Yes	Lyme Disease	☐ No	☐ Yes
TIAs	☐ No	☐ Yes	Enloarged Prostate	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Cataracts	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes	Hypoglycemia	☐ No	☐ Yes	Infection	☐ No	☐ Yes
Bleeding Tendencies	☐ No	☐ Yes	Cancer, Tumor, Masses	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Anemia	☐ No	☐ Yes	HIV/AIDS	☐ No	☐ Yes	Other	☐ No	☐ Yes
Asthma	☐ No	☐ Yes	Eczema, Hives, Rashes	☐ No	☐ Yes	List Here:_____		
Bronchitis	☐ No	☐ Yes	Depression	☐ No	☐ Yes	_____		

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

TYPE	DATE	HOSPITAL

Do you have any problems with Anesthesia? ☐ No ☐ Yes If YES, Please Describe Below:

_____

CURRENT MEDICATIONS

LIST ALL PRESCRIPTION, NON-PRESCRIPTION.
HOMEOPATHIC, VITAMINS, NUTRITIONAL SUPPLEMENTS

_____

_____

_____

_____

Are you on any blood thinners? ☐ No ☐ Yes

Are you on Aspirin? ☐ No ☐ Yes

ALLERGIES / SENSITIVITIES

MEDICATIONS	☐ No	☐ Yes
ADHESIVE TAPE	☐ No	☐ Yes
METAL ALLERGY (Costume Jewelery, Etc.)	☐ No	☐ Yes
LATEX	☐ No	☐ Yes
ANY OTHER ALLERGIES (Food, etc.)	☐ No	☐ Yes

If YES to any of the above, provide details:

_____

_____

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME _____ **DATE OF BIRTH** _____

REVIEW OF SYSTEMS

Do you have or have you had any of the following within the past year? *Please Check All Answers - Whether "Yes" or "No"*

HEAD & NECK

Chronic Headaches	☐ No	☐ Yes
Lumps or Swellings	☐ No	☐ Yes
Stiff or Painful Neck	☐ No	☐ Yes

EYES

Blurred or Double Vision	☐ No	☐ Yes
Watering or Itchiness of Eyes	☐ No	☐ Yes
Any Change or Decline in Vision	☐ No	☐ Yes

EARS

Earache{s}		
Drainage Discharge from Ear(s)	☐ No	☐ Yes
Ringing / Noise in ear(s)	☐ No	☐ Yes
Difficulty Hearing	☐ No	☐ Yes

NEUROLOGIC

Frequent Dizziness	☐ No	☐ Yes
Numbness / Tingling	☐ No	☐ Yes
Fainting	☐ No	☐ Yes
Convulsions / Seizures	☐ No	☐ Yes
Trembling	☐ No	☐ Yes
Memory Difficulties	☐ No	☐ Yes

MUSCULOSKELETAL

Recurrent Back or Neck Pains	☐ No	☐ Yes
Joint Pains or Problems	☐ No	☐ Yes
Muscle Pains	☐ No	☐ Yes

CARDIOVASCULAR / CIRCULATION

Chest Pain, Tightening or Pressure	☐ No	☐ Yes
Fast or Irregular Heart Rate	☐ No	☐ Yes
Leg Cramps on Walking or at Night	☐ No	☐ Yes
Swelling of Hands, Ankles, or Feet	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes
Varicose Veins	☐ No	☐ Yes
Dizziness or Lightheadedness	☐ No	☐ Yes
Sleep on Two or more pillows	☐ No	☐ Yes

RESPIRATORY

Chronic or Frequent Cough	☐ No	☐ Yes
Coughed up Blood	☐ No	☐ Yes
Shortness of Breath	☐ No	☐ Yes
Wheezing or Asthma	☐ No	☐ Yes

CONSTITUTIONAL

Recent Weight Change	☐ No	☐ Yes
Recurrent Fevers	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes

MOUTH

Taste Changes	☐ No	☐ Yes
Sore Tongue, Sore or Swollen Gums	☐ No	☐ Yes
Dental Problems	☐ No	☐ Yes

NOSE / THROAT

Frequent Colds Or Sneezing	☐ No	☐ Yes
Nose Bleeds	☐ No	☐ Yes
Difficulty Swallowing	☐ No	☐ Yes
Hoarseness of Voice	☐ No	☐ Yes
Broken Nose or Deviated Septum	☐ No	☐ Yes
Snoring	☐ No	☐ Yes

DIGESTIVE

Nausea or Vomiting	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Vomiting of Blood	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Pain w/ Stool or Rectum	☐ No	☐ Yes
Gray or Black Stools	☐ No	☐ Yes
Blood in Stool or Rectum	☐ No	☐ Yes
Charge in Bowel HAbits	☐ No	☐ Yes
Excess Gas, Bloating	☐ No	☐ Yes
Hemorrhoids	☐ No	☐ Yes
	☐ No	☐ Yes

GENITOURINARY

Painful or Burning	☐ No	☐ Yes
Frequent or Nocturnal Urination	☐ No	☐ Yes
Difficulty Starting or Stopping Urination	☐ No	☐ Yes
Loss of Control or Dribbling of Urine	☐ No	☐ Yes
Brown or Bloody Urine	☐ No	☐ Yes
Prostate Problems (Men only)	☐ No	☐ Yes

WOMEN ONLY: MENSTRUAL HISTORY

Date of Last Menstrual Period	_____	
Pregnancy	☐ No	☐ Yes

ENDOCRINE

Excessive Thirst or Urination	☐ No	☐ Yes
Inability to Tolerate Heat or Cold	☐ No	☐ Yes
Change in Skin or Hair Texture	☐ No	☐ Yes

SKIN

Rashes or Lesions	☐ No	☐ Yes
Dry, Itchy Skin	☐ No	☐ Yes
Changes in Warts or Moles	☐ No	☐ Yes
Bruises Easily	☐ No	☐ Yes
Other Skin Problems	☐ No	☐ Yes

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME _____ **DATE OF BIRTH** _____

SOCIAL HISTORY

Smoker: ☐ No ☐ Yes

Packs / Cigars per day _____ for _____ months / years

Alcohol:

Never ☐ Rarely ☐ Social (1 or 2 times a month)

Daily (1 or more per day)

OCCUPATION _____

EMPLOYER _____

Do You live alone? ☐ No ☐ Yes

If No, with who? _____

DOES YOUR FAMILY HAVE A HISTORY OF:

Deep Vein Thrombosis ☐ No ☐ Yes

Pulmonary Embolism ☐ No ☐ Yes

Bleeding Disorders ☐ No ☐ Yes

Hypercoagulation Disorder ☐ No ☐ Yes

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brother / Sister				
1.				
2.				
3.				
Husband / Wife				
Son Daughter				
1.				
2.				
3.				

NOTE

This is a Confidential Record of your Medical History and will be maintained by Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C. Information contained here will not be released to any person without your Authorization.

To the best of my knowledge, the questions in this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the Physician of any changes in my (my child's) medical status.

I also authorize Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C. to perform the neccessary health care services I (my child) may need.

PATIENT / AUTHORIZED REPRESENTATIVE / PARENT / LEGAL GUARDIAN - SIGNATURE DATE

PHYSICIAN'S REVIEW SIGNATURE DATE

Statement of Discrimination

Somers Orthopaedic Surgery & Sports Medicine Group, PLLC, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Somers Orthopaedic Surgery & Sports Medicine Group, PLLC, cumple con las leyes federales de derechos civiles y no discrimina por raza, color, origen nacional, edad, discapacidad o sexo.