NYSMI NEW YORK SPORTS MEDICINE INSTITUTE

Orthopedic Surgery | Physical Therapy | Concussion Care

NAME: _____DATE: _____DOB:_____

AGE: _____HEIGHT:_____ WEIGHT: _____

Referring doctor (if applicable**):** _____

Doctor's address: _____

_____

History of Present Illness

Why are you seeing the doctor today? _____

_____

Date of Injury/Onset of Symptoms: _____

Your current problem is a result of a(n): (Please circle the correct reason)

Sport injury Work Injury Accident Unknown

Other: _____

Treatment since injury/Onset of symptoms:

Medications: (Include any prescription drugs, or any drugs you buy over-the-counter)

_____

Physical Therapy: YES/NO Results: _____

Cortisone: YES/NO # of injections _____ Results: _____

Surgery: Yes/NO Date: _____ Type: _____

Circle all imaging that you have had: X-RAY MRI CT (CAT) scan

Past Medical History

Are you being treated for any current medical problems? YES/NO

Explain, if Yes: _____

Please check any illness you have had or presently have:

___ Anemia	___ Arthritis	___ Asthma
___ Bleeding tendency	___ Blood Clots	___ Cancer (type) _____
___ Chest pain	___ Colitis	___ Congestive Heart Failure
___ COPD	___ Depression	___ Diabetes
___ Diverticulitis	___ Dizziness/fainting	___ Gallstones
___ Glaucoma	___ Gout	___ Heart Attack
___ Heart Palpitations	___ Hepatitis	___ High Blood Pressure
___ HIV	___ Kidney Disease	___ Liver Disease
___ Lupus	___ Numbness	___ Pacemaker
___ Phlebitis	___ Pneumonia	___ Reflux
___ Rheumatic fever	___ Sciatica	___ Seizures
___ Shortness of breath	___ Stroke/TIA	___ Thyroid disease
___ Tuberculosis	___ Ulcers	___ Varicose Veins

___Other:_____

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Past Surgical History

DATE: SURGERY:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: (Medications, Food, Shellfish, Dyes, Iodine, Adhesives, etc.)

List any allergies and type of reaction: _____

_____

Medications: (Please include any prescription drugs, over-the-counter drugs, vitamins, minerals, and herbs)

_____

_____

_____

Social History

Do you drink alcohol? (Please circle): Never Socially Daily

Have you ever smoked? YES/NO Currently? YES/NO # of packs a week _____

Any illicit drug use? YES/NO If yes, type: _____

Any history of substance abuse? YES/NO Type: _____

Do you exercise? (Please circle) Daily Weekly Rarely Never

What type of exercise? _____

----------**For doctor's use**----------

HPI:

PE:

XR/MRI/CT:

A/P:

_____ M.D. Date: _____

New York Sports Medicine Institute | Orthopedic Surgery

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