GENESEE ORTHOPEDICS AND PLASTIC SURGERY ASSOCIATES, P.C.

"PLEASE PRINT"

Last Name: First Name: _____, _____	**TODAY'S DATE: _____/_____/_____** DOB ____/____/_____ Age: _____ Sex: M / F
Primary Care Physician/Family Dr. _____	Were you referred by this Dr.? ☐Yes ☐ No Or someone else? _____

Which pharmacy do you use?_____

Problem you are here for today: _____

_____

_____

PAIN LEVEL TODAY: (circle) 1 2 3 4 5 6 7 8 9 10

WORK RELATED INJURY: ☐Yes ☐ No **NO-FAULT INJURY:** ☐Yes ☐ No

MEDICATIONS

Please list all medications, including dietary supplements you are taking:

Medication	Dosage
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____
8._____	_____
9._____	_____
10._____	_____
11._____	_____
12._____	_____
13._____	_____
14._____	_____

ALLERGIES

List all allergies (medications and other substances) and reaction:

_____

_____

PAST SURGICAL HISTORY

List all operations you have had and when:

_____

_____

_____

FRACTURE HISTORY

List all bones you have broken and when:

_____

_____

PAST MEDICAL HISTORY

Have you had any of the following medical problems?
Please circle specific type for each condition.

ANESTHESIA COMPLICATIONS IF SO, WHAT?	☐Yes ☐ No
ARTHRITIS : Osteo / Rheumatoid	☐Yes ☐ No
CANCER If yes, type:	☐Yes ☐ No
DIABETES: Type I / Type II	☐Yes ☐ No
DVT/BLOOD CLOT	☐Yes ☐ No
HEART DISEASE / ATTACK (MI) : DATE: / /	☐Yes ☐ No
HEPATITIS: (A) (B) (C) (D)	☐Yes ☐ No
HIGH BLOOD PRESSURE	☐Yes ☐ No
HIGH CHOLESTEROL	☐Yes ☐ No
HIV / AIDS	☐Yes ☐ No
KIDNEY DISEASE	☐Yes ☐ No
LUNG DISEASE / ASTHMA	☐Yes ☐ No
MULTIPLE SCLEROSIS	☐Yes ☐ No
RHEUMATIC / SCARLET FEVER	☐Yes ☐ No
SLEEP APNEA	☐Yes ☐ No
STROKE: Ischemic / Hemorrhagic / TIA	☐Yes ☐ No
THYROID DISEASE	☐Yes ☐ No
OTHER:	☐Yes ☐ No

SOCIAL HISTORY

Do you use tobacco/nicotine?	☐Yes ☐ No
□ cigarettes/cigars □ chewing tobacco □ E-cig/vaping	
Alcohol	☐Yes ☐ No
Other Substances	☐Yes ☐ No
Marital Status:	☐Yes ☐ No
Are you pregnant	☐Yes ☐ No
Are you currently working?	☐Yes ☐ No
Occupation:	
Hand Dominance:	□ Right Handed □ Left Handed

PLEASE TURN OVER TO COMPLETE FORM►

FAMILY HISTORY

FATHER: Living? ☐Yes ☐ No
Medical History: _____

MOTHER: Living? ☐Yes ☐ No
Medical History: _____

REVIEW OF SYSTEMS

Do you currently have any of these symptoms?

CONSTITUTIONAL	
Fever/Chills	☐Yes ☐ No
Weight Change? Loss / Gain	☐Yes ☐ No
EYES	
Glasses / Contacts	☐Yes ☐ No
Cataracts	☐Yes ☐ No
Decreased Vision	☐Yes ☐ No
EARS, NOSE, THROAT	
Hearing Problems/loss	☐Yes ☐ No
Sinus Problems	☐Yes ☐ No
HEART	
Chest Pain	☐Yes ☐ No
Palpitations	☐Yes ☐ No
Poor Circulation	☐Yes ☐ No
LUNGS	
Shortness of Breath	☐Yes ☐ No
Cough	☐Yes ☐ No
Asthma	☐Yes ☐ No
Pulmonary Embolism	☐Yes ☐ No
GASTROINTESTINAL	
Stomach Ulcers	☐Yes ☐ No
Reflux Disease (Heartburn)	☐Yes ☐ No
Diarrhea	☐Yes ☐ No
GENITOURINARY	
Blood in Urine	☐Yes ☐ No
Bladder Infection	☐Yes ☐ No
Urinary Incontinence (Do you leak urine?)	☐Yes ☐ No
Nocturia (Get up at night to urinate?)	☐Yes ☐ No

MUSCULOSKELETAL	
Joint Pain	☐Yes ☐ No
Joint Swelling	☐Yes ☐ No
NEUROLOGICAL	
Frequent Headaches	☐Yes ☐ No
Paralysis or Weakness	☐Yes ☐ No
Dizziness	☐Yes ☐ No
SKIN	
Rash or Psoriasis	☐Yes ☐ No
Dry Skin or Eczema	☐Yes ☐ No
PSYCHIATRIC	
Depression or Anxiety	☐Yes ☐ No
Bipolar Disease	☐Yes ☐ No
HEMATOLOGIC	
Bleeding Problems	☐Yes ☐ No
Bruise Easily	☐Yes ☐ No
Previous Blood Transfusion	☐Yes ☐ No
DVT / Blood Clot	☐Yes ☐ No
IMMUNE SYSTEM (ALLERGIES)	
Allergies to foods or things other than medicine.	☐Yes ☐ No
If so, what:	
Other Problems:	

VITALS (Taken Today):
BLOOD PRESSURE: _____/_____
PULSE: _____

CURRENT HEIGHT: _____ WEIGHT: _____