CNY Orthopedic Sports Medicine, P.C.
MEDICAL & SOCIAL HISTORY

Date: _____

NAME: _____ Referring Physician: _____
Occupation: _____ Height: _____ Weight: _____ Age: _____
Are you RIGHT or LEFT Hand Dominant? _____

PRESENT INJURY
Date of Injury: _____ Area of Injury: _____
Where Injury Occurred: _____ How Injury Occurred: _____
_____

If applicable, please check the symptoms you are experiencing:
Shoulder Symptoms:
Hand Numbness or Tingling: ____ Arm Numbness or Tingling: ____ Night Pain: ____
Catching: ____ Neck Pain: ____ Instability: ____ Pain w/ Throwing: ____
Cocking: ____ Follow Through: ____
Knee Symptoms:
Pain: ____ Swelling: ____ Give-Way: ____ Popping: ___ Locking: ____
Catching: ____

What sports are you interested in or play regularly? _____
_____

PAST MEDICAL HISTORY Please Check If You Have Any Of The Following:

Lung Problems ____ (If so, what type?) _____
Cancer ____ (If so, what type?) _____
Stomach Problems ____(i.e. ulcer, hiatal hernia) (If so, what type?) _____
Neurological ____ (if so, what type?) _____
Arthritis ____ Blood Clots ____ High Blood Pressure ____ Heart Disease ____ Diabetes ____
Any other conditions not listed above for which you take medication or see another provider:
_____

PAST SURGICAL PROCEDURES & DATES: _____
_____

PAST HOSPITALIZATIONS: (Other than above surgeries – include birth of children)
_____
_____

CURRENT MEDICATIONS (Include Aspirin and over-the-counter medications taken regularly)
_____
_____

ALLERGIES: (Especially to medications or shell fish)

MEDICATION:	**REACTION:**
_____	_____
_____	_____
_____	_____

Can you tolerate Aspirin? _____ Have you had stomach ulcers? _____

FAMILY & SOCIAL HISTORY

Do you smoke? _____ How many per day? _____ For how many years? _____
Do you use alcohol? _____ How much per week? _____
Diseases that run in your family: (i.e. high blood pressure, heart disease, cancer) _____
_____
Are you married? _____ Do you have children? _____

REVIEW OF SYSTEMS (Please Circle any of the Following)

Constitutional Symptoms
(fever, weight loss, fatigue)

Eyes
(double vision, blurring, trauma, glasses)

ENT & Mouth
(deafness, sinusitis, ear ringing, hoarseness, dizziness)

Cardiovascular
(chest pain, palpitations, high blood pressure, irregular heart beats)

Respiratory
(shortness of breath, asthma, cough, cough producing bloody mucous)

Stomach
(appetite, weight change, diarrhea, constipation, abdominal pain)

Bowel/Bladder
(hesitancy, incontinence, painful urination, pregnancies)

Musculoskeletal
(fractures, sprains, pain, swelling, arthritis, stiffness, muscle wasting)

Skin/Breast
(color, temperature, rashes, lesions, scars, masses, ulcers)

Neurological
(difficulty w/ speech or swallowing, history of stroke, numbness, tingling, seizures, weakness, visual changes, balance, memory, coordination problems)

Psychological
(depression, mood changes, hallucinations, sleep disturbances)

Endocrine
(excessive thirst, excessive eating, hyperactivity, growth or hair changes)

Hematologic/Lymphatic
(bleeding tendency, enlarged or painful lymph nodes, anemia)

I affirm that to the best of my knowledge, this is my complete medical and social history. (SIGNATURE): _____