North Shore Orthopedic Surgery and Sports Medicine
Initial Visit History Form

Name: _____ Date: _____

Date of Birth: _____ Height_____ Weight_____

Name of your Primary Care Doctor: _____

Were you referred by a physician? Y / N Name: _____ Phone : _____

Reason for today's visit (briefly state history of problem and when symptoms began):

_____

_____

_____

_____

Problem due to: (check): ____ car accident ____ work-related ____ school injury ____other

Dominant Hand: **Right** ☐ **Left** ☐

Past Medical History: Have you ever had any of the following medical problems?

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Stroke	___	___	Cancer	___	___	Liver Disease	___	___	Rheumatoid Arthritis	___	___	History of PE
___	___	High Blood Pressure	___	___	Asthma	___	___	Kidney Disease	___	___	Arthritis	___	___	Hepatitis
___	___	Heart Disease	___	___	Thyroid Disease	___	___	Ulcers	___	___	Bleeding Disorder	___	___	Lyme Disease
___	___	Diabetes Arthritis	___	___	Neurologic Disorder	___	___	Colitis	___	___	History of Blood Clots	___	___	Tuberculosis

Explain any positive responses above (and other medical problems not listed): _____

_____

_____

Past Surgical History: (list all surgeries)

_____

_____

_____

Medications:

_____

_____

_____

_____

Medication Allergies: _____

Review Of Symptoms: Are you having problems with any of the following?

Eyes:	Visual Disturbance	☐ Yes	☐ No	Explain: _____
Ear/Nose/Throat:	Sore Throat	☐ Yes	☐ No	Explain: _____
Respiratory:	Shortness of Breath (Dyspnea)	☐ Yes	☐ No	Explain: _____
Constitutional:	Recent Weight Loss	☐ Yes	☐ No	Explain: _____
	Chills	☐ Yes	☐ No	Explain: _____
	Fever:	☐ Yes	☐ No	Explain: _____

Psychiatric:	Depression	☐ Yes	☐ No	Explain: _____
	Eating Disorder:	☐ Yes	☐ No	Explain: _____
Musculoskeletal:	Joint Pain	☐ Yes	☐ No	Explain: _____
	Stiffness:	☐ Yes	☐ No	Explain: _____
	Swelling:	☐ Yes	☐ No	Explain: _____
Hematologic/Lymphatic:	Anemia:	☐ Yes	☐ No	Explain: _____
	Abnormal Bleeding and Brusing	☐ Yes	☐ No	Explain: _____
Genitourinary/Nephrology:				
	Urinary/Bowel Incontinence	☐ Yes	☐ No	Explain: _____
Cardiovascular:	Chest Pain/Pressure	☐ Yes	☐ No	Explain: _____
Gastrointestinal:	Stomach Burning	☐ Yes	☐ No	Explain: _____
Neurologic:	Tingling or Numbness	☐ Yes	☐ No	Explain: _____
Dermatologic:	Rash	☐ Yes	☐ No	Explain: _____
Endocrine:	Thyroid Nodule	☐ Yes	☐ No	Explain: _____
Allergy/Immunology:	Hives	☐ Yes	☐ No	Explain: _____

Family Medical History: List Medical problems of your relatives (ex. Diabetes, cancer):

Grandparents: _____

Mother: _____

Father: _____

Siblings: _____

Children: _____

Social History: Occupation: _____ Working now? ☐ Yes ☐ No ☐ Retired

Do you smoke? ☐ Yes ☐ No ☐ Quit Packs per day: _____ If quit, years smoked: _____years

Alcohol Use (check one): ☐ Never ☐ Occasional ☐ Daily ☐ Heavy ☐ History of Alcoholism

Any history of Drug use (list): _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed Live alone? ☐ Yes ☐ No

Are you on a special diet? _____

Do you exercise / play sports? ☐ Yes ☐ No Describe briefly: _____

Patient Signature: _____ Reviewed by Dr. _____

Date: _____ Date: _____