

Orthopedic Associates of Long Island, LLP

Initial Visit History Form

Name: _____ Date: _____ Social Sec. #: _____

Phone: _____ Age: _____ Sex: M / F Height: _____ Wt: _____

Name of your Primary Care Doctor: _____

Did you bring Xrays today?: Y/N: Name: _____ Phone: _____

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

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

Yes	No	Yes	No	Yes	No
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___

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

Past Surgical History: (list all surgeries)

Medications (list):

Allergies (If none, indicate):

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

Yes	No	Yes	No	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: _____yrs.

Alcohol use(circle one): Never / Occasional / Daily / Heavy / History of alcoholism

Any history of Drug use (list): _____

(circle one) Married / Single/ Divorced / Widowed Live alone? yes /no

Are you on a special diet? _____

Do you exercise / play sports (describe briefly)? _____