ROCHESTER REGIONAL HEALTH

Orthopaedics at Red Creek
125 Red Creek Drive; Suite 205
Rochester, NY 14623
p.585.723.7600
f.334.6373

Orthopaedics at Chili
2115 Chili Avenue
Rochester, NY 14624
p.585.723.7600
f.247.0075

**MEDICAL HISTORY PLEASE PRINT AND COMPLETE THE ENTIRE FORM**

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: ☐ Male ☐ Female Dominant Hand: Right/ Left (please circle)

Height:_____ Weight: _____ Occupation: _____

Are you currently working Y/N Retired Y/N Year::_____ Disabled Y/N Since:_____

**Current Medical History: Please circle Y or N**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | Y | N | Diabetes | Y | N | Heart Trouble | Y | N |
| Respiratory Problems | Y | N | Stroke | Y | N | Cancer | Y | N |
| Gastrointestinal Problems | Y | N | HIV/AIDS | Y | N | Bleeding Problems | Y | N |
| Pulmonary Embolism | Y | N | Blood Clot | Y | N | Other _____ | | |

Current Medications: (if you have a list we will copy) _____

_____

Allergies with Reaction: _____

Past Hospitalizations/Surgeries/Injuries and Approximate Dates: _____

_____

Past Problems with Anesthesia? Y/N If Yes please explain: _____

**Family History**: Please list any FAMILY history of medical problems (e.g. Heart Disease, Stroke, Diabetes)

Father: Living/Deceased_____Mother: Living/Deceased_____

Siblings: Living/Deceased _____Other: Living/Deceased_____

**Social History:**

Marital Status: Single Married Separated Widowed Divorced Partner

Tobacco Use: Never Packs/day_____ How many years _____ Quit/when _____

Alcohol Use: Never Rarely Moderate Daily How Much? _____

Recreational Drug Use: No Yes Type and Frequency _____

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Name:_____ DOB:_____

**Review of Systems: Please circle Y or N**

| | | | | | |
|---|---|---|---|---|---|
| Good general health | Y N | Hearing loss | Y N | Vision problems | Y N |
| Recent weight change | Y N | Sinus problems | Y N | Nausea/vomiting | Y N |
| Night sweats/fevers | Y N | Nose bleeds | Y N | Abdominal pain | Y N |
| Fatigue | Y N | Shortness of breath | Y N | Rectal bleeding | Y N |
| Chest pain | Y N | Cough | Y N | Bowel problems | Y N |
| Palpitations | Y N | Wheezing/Asthma | Y N | Change in hair/nails | Y N |
| Swelling hands/feet | Y N | Frequent headaches | Y N | Rashes or itching | Y N |
| Excessive thirst/urination | Y N | Convulsions/seizures | Y N | Breast lump | Y N |
| Thyroid disease | Y N | Numbness/tingling | Y N | Breast pain or discharge | Y N |
| Hormone problem | Y N | Bruise easily | Y N | Insomnia | Y N |
| Blood in urine | Y N | Slow to heal | Y N | Confusion/memory loss | Y N |
| Kidney stones | Y N | Enlarged glands | Y N | Depression | Y N |

All other systems reviewed and negative_____.

**Present Orthopaedic Complaint:** _____ Severity of Pain (0 least 10 worst) 0 1 2 3 4 5 6 7 8 9 10

Date of injury/Onset: _____Was injury/onset related to: WORK Y/N MVA Y/N OTHER _____

How did the injury or onset occur: _____

Associated symptoms? (swelling, locking, bruising, numbness)_____

What makes your symptoms better? (rest, heat,cold,elevation,physical therapy)_____

Any previous treatment: (include any medications prescribed, physical therapy, surgery, etc) _____

_____

Were Xrays taken for this complaint? Y/N Where/When? _____

Name of Physician(s) who treated you and when: _____

**Patient Statement: To my best knowledge, the above information is accurate and complete.**

**Signed: _____ Date: _____**

**Reviewed by MD/PA: Signed: _____ Date: _____**