NF_WC_SP_

DS/EN/15

History Sheet

Date_____

NAME_____SEX____

DATE OF BIRTH_____ SOCIAL SECURITY_____ MARITAL STATUS____

ADDRESS _____

CITY/STATE _____ ZIPCODE_____

PHONE#_____CELLPHONE_____CELL COMPANY_____

E-MAIL _____

WHO IS YOUR PRIMARY DOCTOR? NAME: _____PHONE#: _____

ADDRESS: _____

REFERRED BY: DOCTOR/FRIEND/ETC. _____

ADDRESS_____CITY/STATE_____PHONE#_____

INSURANCE_____

CHIEF COMPLAINT _____

DATE OF ONSET_____TIME_____PLACE_____

HOW DID INJURY OCCURY _____

_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS _____PHONE# _____

ARE YOU WORKING_____ DATE YOU STOPPED WORKING_____

_____

NOTE: THE PATIENT IS RESPONSIBLE FOR THE ENTIRE FEE (INCLUDING COPAYS AND/OR COINSURANCE WHEN APPLICABLE) REGARDLESS OF ANY INSURANCE CLAIM. FEES ARE PAYABLE UPON COMPLETION OF VISIT. THANK YOU.

PATIENT'S SIGNATURE_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize to furnish any information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

DATE_____ PATIENT'S SIGNATURE_____

HISTORY & PHYSICAL

Patient Name _____

Date _____

Family History: Any blood relative has suffered any of the following. Please circle the number and indicate which relative.

1) Epilepsy	6) Thyroid	11) Osteoporosis	16) Alcoholism _____
2) Migraine	7) Hay Fever	12) Arthritis	17) Cancer _____
3) Glaucoma	8) Asthma	13) Heart Disease	18) _____
4) Mental Ill	9) Anemia	14) Stroke	19) _____
5) Diabetes	10) Bleeds Easily	15) Hypertension	20) _____

Hospital Admissions — Year — Illness or Operation

_____

_____

_____

Social History:

Occupation: _____

Smoking:

Currently? Yes__ No__

Previously? Yes__ No__

Physical Exam:

Height_____ft_____in Weight_____lbs. Blood Pressure_____

Medical History: Have you had any problems with any of the following?

Heart	Yes __No __	Clotting	Yes __No__
Psychological	Yes __No__	Cancer	Yes __No__
Diabetes	Yes __No__	Skin	Yes __No__
Urinary/Kidney	Yes __No__	Eyes (glasses)	Yes __No__
Liver	Yes __No__	Orthopedic	Yes __No__
Neurologic	Yes __No__	Cholesterol	Yes __No__
Blood Pressure	Yes __No__	Thyroid	Yes __No__
Lung	Yes __No__	Hemorrhoids	Yes __No__
Stomach/Intestine	Yes __No__	Endocrine	Yes__NO__

Females:

Date Expecting Next Period: _____

DO NOT WRITE BELOW THIS LINE

Allergic/Immunologic _____ Cardiovascular_____

Constitutional Symptoms: _____ Endocrine_____ ENT _____

Eyes _____ GI _____ GU _____

Integumentary _____

Lymphatic _____

Musculoskeletal: **Negative Except for History of Present Illness**

Psychiatric _____ Reproductive_____ Respiratory _____

_____**Remainder of systems left blank were inquired after and are negative**

Patient _____ **Date**_____

Medication List

Medication	Dosage	#Times a day	Reason for Medication (e.g. High Blood Pressure)

List any allergies and reactions to medications:

_____

_____

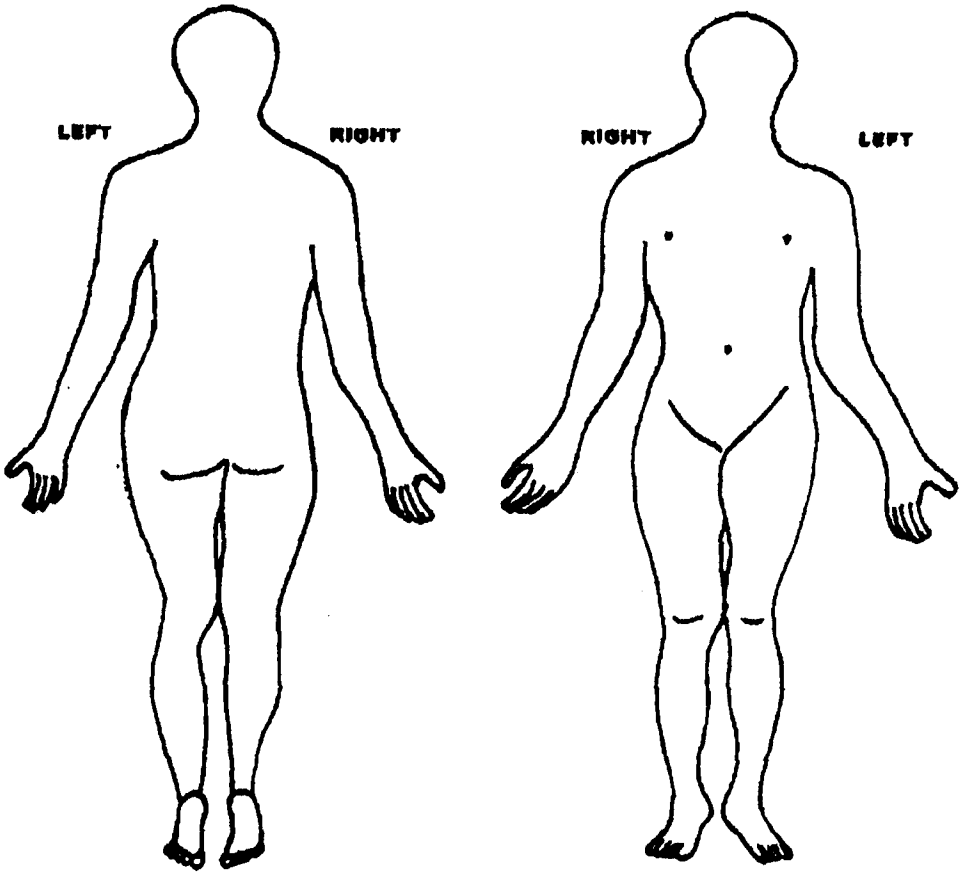
_____

_____

NAME: _____ DATE: _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

NUMBNESS	PINS & NEEDLES	BURNING	STABBING	PAIN
-----	OOOOO	XXXXX	/////	.....



JOSEPH I. STEIN, M. D., F.A.C.S.
ORTHOPAEDIC SURGEON
SPORTS MEDICINE PHYSICIAN
5319A 16TH AVENUE
BROOKLYN, N. Y. 11204
(718) 851-2663

DIPLOMATE AMERICAN BOARD OF ORTHOPAEDIC SURGERY

FELLOW AMERICAN COLLEGE OF SURGEONS

FELLOW AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Knee History

Name:_____

Date:_____

Please circle the correct answer.

1. Which knee bothers you? Right /Left/Both
2. How long has it been bothering you? _____
3. Is your current visit related to a single specific injury to the knee? Yes/No
4. If so what was the day, date, and nature of this injury?_____
5. Does the pain in the knee awaken you at night? Yes/No
6. Are you taking anti-inflammatories for pain in your knee? Yes/No
7. If so what are they?_____
8. Does your knee swell up? Yes/No When?_____
9. Does your knee give way on you or buckle? Yes/No
10. Does you knee lock (a true solid locking so that you can't move it unless you jiggle it around for a few seconds)? Yes/No
11. Does your knee stiffen up on you? Yes/No
12. If so when?_____
13. Does your knee bother you going down stairs? Yes/No
14. Does your knee bother you going up stairs? Yes/No
15. If both knees bother you, which bothers you more? Right/Left
16. What things are you unable to do that you would like to do?_____
17. Are there any sports activities that you have had to give up because of pain in the knee?_____
18. Have you had any previous surgery on the knee? Yes/No
19. If so what type of surgery and when?_____
20. Have you ever previously had an MRI? Yes/No. When?_____
21. Have you ever previously had an x-ray? Yes/No. When?_____
22. If so when?_____