CONNECTICUT ORTHOPAEDIC AND HAND SURGERY CENTER

Welcome to our office. To help us better evaluate your condition, please complete the following form. If you have any questions we will be glad to help you. Thank you. DOB:___________________________

Name:____ Occupation:_________________________

Primary Care Doctor:_______________________________Referred by:_________________________

List all Medications:____

Do you have any drug allergies:?_________ if "yes" list:_______________________________________

List all surgeries you have had:____

Location of pain or injury:____

Date injury/problem sustained or noticed on:____

Past Medical History: (Please circle any illnesses that you have been treated for. Items not circled are understood to be negative) :

Abnormal bleeding	Pneumonia	Cancer	Diabetes	Heart Disease
Ulcer	Hepatitis	Hypertension	Kidney disease	Anemia
Arthritis	Osteoporosis	Liver disease	Asthma	Gout
Anxiety	Peripheral Vascular disease		Emphysema	Phlebitis
Stroke	Tuberculosis	Polio	Rheumatic Fever	Blood Clot
Back/neck injury	AIDS/HIV Positive		Thyroid disorder	Epilepsy/Seizure

Other____ None:______________

Height:_________Weight:___________Age:____________Marital Status S M W D

Do you smoke tobacco: Yes____No___ How many packs a day?_______ How many years?_____

Do you drink alcohol? Yes___No_____ Frequency?_____________________________________

Have you ever used or been dependent on drugs? Yes___No___ Type?______________________

Family History (please circle any conditions your family members have (items not circled are understood to be negative)

Abnormal bleeding	Pneumonia	Cancer	Diabetes	Heart Disease
Ulcer	Hepatitis	Hypertension	Kidney disease	Anemia
Arthritis	Osteoporosis	Liver disease	Asthma	Gout
Anxiety	Peripheral Vascular disease		Emphysema	Phlebitis
Stroke	Tuberculosis	Polio	Rheumatic Fever	Blood Clot
Back/neck injury	AIDS/HIV Positive		Thyroid disorder	Epilepsy/Seizure

Other____ None:____________________________

Have you had any recent episodes of: (please circle. Items not circled are understood to be negative):

Fever	Weight loss	Shortness of breath	Swelling	Visual Changes
Vomiting	Diarrhea	Rashes	Hearing Loss	Chest Pain
Joint Pain	Depression	frequent urination	hot flashes	frequent infection
Inflammation	blood in urine	blood in stool	anxiety	NONE

Patient Signature:____Date:____________

For office use only:

Reviewed by:____Date:___________

Reviewed by:____Date:___________