

STEPHEN FEALY, MD
HOSPITAL FOR SPECIAL SURGERY
DEPARTMENT OF SPORTS MEDICINE & SHOULDER SERVICE
523 EAST 72ND STREET, 2ND FLOOR
212-606-1894

Name: _____ Date: _____

Date of birth: _____ Age: _____

Email address: _____

Referring doctor (if any): _____

Why are you seeing the doctor?:

How long has this problem existed? _____

Is the problem a result of:

_____ sports injury

_____ work injury

_____ accident

_____ fall _____ lifting _____ pulling

_____ hit by object _____ squatting

What have you done for this problem to date?

Medicine: _____

Physical therapy: _____

Injections (steroid shot): _____

Surgery: _____

How many days a week do you engage in sports or work out? _____

What type of exercise do you do? _____

Do you smoke? _____ # of packs? _____

Do you drink? _____ # of drinks? _____ day/week/mo

Do you have a history of substance abuse? _____

Medical History: Are you currently having or have you had problems with:

	YES	NO	Type
• Asthma/ lungs	_____	_____	_____
• High blood pressure	_____	_____	_____
• Heart disease	_____	_____	_____
• Digestion	_____	_____	_____
• Bleeding problems	_____	_____	_____
• High cholesterol	_____	_____	_____
• Immune deficiency	_____	_____	_____
• Difficulty urinating	_____	_____	_____
• Cancer	_____	_____	_____
• Diabetes	_____	_____	_____
• Sleep Apnea	_____	_____	_____

Any family members with similar orthopaedic history or experiences?

Do you take any medications?

Previous surgery:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Do you have any allergies to medications?

Medicine: _____ Reaction: _____
_____ Reaction: _____

Other allergies (type): _____

Reviewed by: _____ Date: _____