

ISLAND ORTHOPAEDICS AND SPORTS MEDICINE, P.C.

Medical and Surgical Information

PATIENTS NAME: _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ MALE FEMALE

FAMILY PHYSICIAN NAME AND ADDRESS: _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

ARE YOU A: NEW PATIENT FORMER PATIENT OF DR CARROLL
 IF FORMER PATIENT, FOR WHAT PROBLEM AND WHEN:

SPECIFIC COMPLAINT TODAY: (Describe the area of discomfort and indicate side.)

IS THIS A **WORK RELATED** INJURY? YES NO **CAR ACCIDENT** YES NO

DATE OF ONSET OR INJURY? _____

WHERE DID INJURY OCCUR? _____ HOW? _____

HAVE YOU BEEN TREATED FOR THIS COMPLAINT IN THE PAST? YES NO

IF YES, EXPLAIN:

HAVE YOU HAD ANY X-RAYS OR OTHER TESTING DONE PERTAINING TO THIS INJURY?
 SUCH AS CAT SCAN, MRI, BONE SCAN, ETC, IF SO WHERE AND WHEN?

RECENT MEDICAL ILLNESS

	YES	NO		YES	NO		YES	NO	HEIGHT WEIGHT PREGNANT? YES <input type="checkbox"/> NO <input type="checkbox"/> B/P
HEADACHE			BRONCHITIS			ANGINA			
VISUAL DISTURBANCE			DIARRHEA			DIABETES			
EARACHE			CONSTIPATION			ASTHMA			
HIGH BLOOD PRESSURE			HEART ATTACK			ULCER			

HISTORY OF CANCER: (YOURSELF/FAMILY)

OTHER:

CURRENT MEDICATION:

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO
 IF SO PLEASE LIST AND WHAT REACTION YOU HAD AND WHEN:

HABITS: **ALCOHOL** YES NO **DRUGS** YES NO **SMOKING** YES NO

RECENT HOSPITALIZATIONS:

PAST SURGERY:

SIGNATURE: _____ **DATE:** _____