Howard J. Gelb, MD, PA
SPORTS MEDICINE AND ORTHOPAEDIC CENTER

Auto New Patient Medical History Form

Patient Registration:

Today's Date: _____ Which Physician are you seeing? _____

Name (Last):_____ (First) _____ MI _____

Address: _____ City_____ State_____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: ○ Male ○ Female Date of Birth: _____ Email: _____

Social Security #:_____ Driver's License #: _____ Driver's License State:_____

Local Pharmacy Name: _____ Pharmacy Phone: _____ Occupation:_____

In case of an emergency please contact:

Name:_____ Relationship:_____ Phone: _____

Address:_____ City:_____ State:_____ Zip:_____

Primary Insurance- Please have insurance cards ready to be copied at check in

Primary Insurance carrier: _____ Phone:_____

Policy #:_____ Group #:_____ Insured DOB: _____ Insured SS#: _____

Address:_____ City:_____ State:_____ Zip: _____

Secondary Insurance- Please have insurance cards ready to be copied at check in

Secondary Insurance carrier: _____ Phone:_____

Policy #:_____ Group #:_____ Insured DOB: _____ Insured SS#: _____

Address:_____ City:_____ State:_____ Zip: _____

If the patient is a minor (under age 18)- Please Complete:

Father's Name:_____ Mother's Name:_____

Employer/Position:_____ Employer/Position:_____

Phone:_____ Phone:_____

Auto Liability:

Auto Insurance- Please have insurance cards ready to be copied at check in

Name of Company: _____ Phone:_____

Address:_____ City:_____ State:_____ Zip: _____

Insured's Full Name: _____ Insured's SS# _____ Insured's DOB:_____

Policy #:_____ Claim #:_____

Date of Accident: _____

Primary Insurance- Please have insurance cards ready to be copied at check in

Name of Company: _____ Phone:_____

Address:_____ City:_____ State:_____ Zip: _____

Insured's Full Name: _____ Is this an Employer's Plan? ○ Yes ○ No Insured's SS# _____

Policy #:_____ Group #:_____

Insured DOB: _____ Relationship to insured: (self, spouse, child, other):_____

Do you have an attorney? ○ Yes ○ No If yes, Name: _____ Phone:_____

Address: _____

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Liability Patient Information:

Name (Last):_____ (First) _____ Date:_____

Age: _____ Ht:_____ Wt:_____ ○Male ○Female ○Right Handed ○Left Handed ○Ambidextrous

Occupation:_____

How were you referred to our office? _____

Who is your primary physician? _____

History of Present Illness

Describe the condition that brought you in this office:_____

Is your injury: ○Work ○ Auto Accident ○ Slip & Fall

Accident:

Date when Accident/Injury occurred: _____ Where did Accident/Injury Occur?_____

Description of accident/Injury: _____

If this is an auto accident, were you thrown from the car? ○Yes ○No Did you lose consciousness? ○Yes ○ No

Contributing events of cause for symptoms:

Describe the severity and Quality of pain (sharp, dull, stabbing, etc.)

Select rating of 1-10 for severity of symptoms with 10 being the greatest ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Frequency of symptoms: ○Constant ○Intermittent ○Daily Duration of symptoms: ○Constan ○Hrs ○Mins ○Seconds

Do symptoms include? ○Swelling ○Weakness ○Numbness ○Decreased Motion ○Pins & Needle Sensation ○Other

If applicable, is the joint? ○Popping ○Locking ○Clicking ○Instability/ ○Giving Way ○Other

What activities worsen your condition? _____

When do the symptoms occur? ○Morning ○Afternoon ○Evening ○During Exercise ○ After Exercise

Have you been previously treated for this accident/injury elsewhere? ○Yes ○No If yes, by whom? _____

Past Treatment of your current problem: ○Ice treatment ○Heat treatment ○ Physical therapy

○Rest (Length of time)_____ ○Injections (How Many?)_____ ○Medications

Related past surgeries for condition (specify procedure and date) _____

Patient Name:_____ Height:_____ Weight:_____

Race: ○ African American ○ Asian ○ Caucasian ○ Native American/Alaskan ○ Pacific Islander ○Other ○ Unknown ○ Decline to Answer

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown ○ Decline to Answer

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name):_____Other (ex. Googlesearch): _____

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Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck	○
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back	○
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back	○
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back	○
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks	○
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone	○
Thumb	○ Right	○ Left	Foot	○ Right	○ Left		
Index	○ Right	○ Left	Great Toe	○ Right	○ Left		
Middle	○ Right	○ Left	2nd Digit	○ Right	○ Left		
Third	○ Right	○ Left	3rd Digit	○ Right	○ Left		
Little	○ Right	○ Left	4th Digit	○ Right	○ Left		
			5th Digit	○ Right	○ Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

○ No Injury ○ Injury ☑ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Have you been seen in an ER for this problem? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy)

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

4. Do the symptoms wake you from sleep?

○ Yes ○ No

5. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

History of Present Illness (continued)

6. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

7. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

8. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

9. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	_____
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	_____
Chiropractor	○ Improved	○ Worsened	○ Unchanged	_____
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	_____
HomeExerciseProgram	○ Improved	○ Worsened	○ Unchanged	_____
Surgery	○ Improved	○ Worsened	○ Unchanged	_____
Injections	○ Improved	○ Worsened	○ Unchanged	_____
Bracing	○ Improved	○ Worsened	○ Unchanged	_____
TENS unit	○ Improved	○ Worsened	○ Unchanged	_____

Other/Comments: _____

_____

_____

 Patient Name: _____

Select all previous hospitalizations/surgeries: ○ **None**

○ Aneurysm (Brain) Surgery	○ Hysterectomy
○ Aortic Bypass / Vascular Surgery	○ LAP Band/ Gastric Bypass Surgery
○ Appendectomy	○ Lumpectomy
○ Cataract (Eye) Surgery	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Heart Surgery	○ Stents
○ Hernia Repair	

Orthopedic Surgery:	**Right**	**Left**
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
Total ShoulderReplacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months? ○ **None for all**

				None	Comments
1) GEN	○ Weight Loss	○ Loss of Appetite	○ Fatigue ○ Weakness	○	_____
2) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss	○	_____
3) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	_____
	○ Ear Pain/Ringing	○ Tooth/Gum Issues	○ Nose Bleeds		
4) CV	○ Chest Pain	○ Palpitations	○ Heart Attack	○	_____
	○ Hypertension				
5) RS	○ Chronic Cough	○ PE (pulmonary embolism)	○ Shortness of Breath	○	_____
	○ Pneumonia				
6) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	_____
7) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	_____
	○ Stomach Pain	○ Irregular Periods	○ Vaginal Discharge		
8) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	_____
9) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness		
	○ Blackouts	○ Frequent Headaches			
10) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	_____
11) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		

 Patient Name: _____

12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia	○ DVT	○	_____
13) MUSC	○ Osteo/Arthritis	○ Muscular Weakness	○ Muscular Pain		○	
14) MISC	○ Joint Pain	○ Joint/Limb Swelling	○ Stiffness		○	

Medical Questions

Mark all that currently apply:

○ Pregnant ○ Sleep Apnea ○ Uses a CPAP

Are you taking blood thinners? ○ Yes ○ No

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father

○ None ○ Diabetes ○ Heart Disease ○ Hypertension
○ Bleeding Problems ○ Epilepsy ○ Connective Tissue ○ Muscular Dystrophy
○ Stroke ○ Osteoporosis ○ Rheumatoid Arthritis ○ Cancer
○ Drug Addiction ○ Alcohol Addiction

Complications with Anesthesia: ○ Yes ○ No Reaction:

Comments (ex. cancer type) _____

Mother

○ None ○ Diabetes ○ Heart Disease ○ Hypertension
○ Bleeding Problems ○ Epilepsy ○ Connective Tissue ○ Muscular Dystrophy
○ Stroke ○ Osteoporosis ○ Rheumatoid Arthritis ○ Cancer
○ Drug Addiction ○ Alcohol Addiction

Complications with Anesthesia: ○ Yes ○ No Reaction:

Comments (ex. cancer type) _____

Sibling

○ None ○ Diabetes ○ Heart Disease ○ Hypertension
○ Bleeding Problems ○ Epilepsy ○ Connective Tissue ○ Muscular Dystrophy
○ Stroke ○ Osteoporosis ○ Rheumatoid Arthritis ○ Cancer
○ Drug Addiction ○ Alcohol Addiction

Complications with Anesthesia: ○ Yes ○ No Reaction:

Comments (ex. cancer type) _____

Social History

Do you smoke tobacco? ○ Current, every day smoker ○ Current, some day smoker ○ Former smoker ○ Never
○ Heavy tobacco smoker ○ Light tobacco smoker

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Employment Status? ○ Full-Time ○ Part-Time ○ Unemployed ○ Retired
○ Disabled If no, what date did you last work?

Please list work restrictions, if any: _____

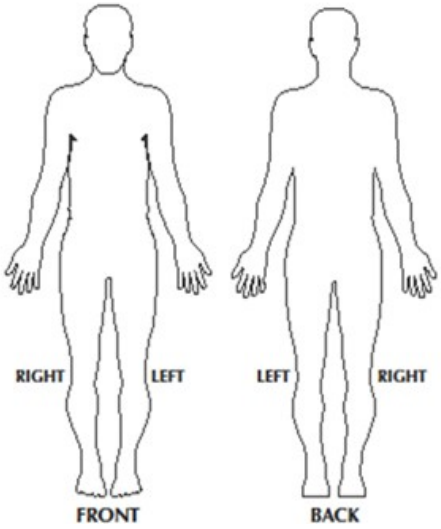
Occupation: _____ Employer: _____ ○ Student

 Patient Name: _____

Pain Diagram

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



Please list all medications you take on a regular basis: ○ None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have any allergies? ○ Yes ○ No

Medication, Relevant Food, or "Seasonal"	If yes, list below: Reaction

 Patient Name: _____

Latex allergy? ○ Yes ○ No

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ Migraines
○ Angina (Chest Pain)	○ Epilepsy	○ MRSA Infection
○ Arthritis Type: _____	○ Fibromyalgia	○ Multiple Sclerosis
○ Asthma	○ Gout	○ Osteoporosis
○ Bone or Joint Infections	○ Heart Attack	○ Pacemaker
○ Bursitis	○ Hepatitis - Type:	○ Pulmonary Embolism (PE)
○ Cancer – Type:	○ HIV/AIDS	○ Bleeding Disorder
○ Celiac Disease	○ High Cholesterol	○ Reaction to Anesthesia – Type:
○ Chemotherapy/Radiation	○ High Blood Pressure	○ Seizures
○ Congestive Heart Failure	○ Hyperthyroidism	○ Serious Illness
○ COPD	○ Hypothyroidism	○ Serious Injuries
○ Crohn's Disease	○ Kidney Disease	○ Stomach Ulcers
○ Diabetes Type: Last A1C:	○ Kidney Stones	○ Stroke / TIA
Last A1C:	○ Liver Disease	○ Tuberculosis
○ Diverticulitis	○ Lyme Disease	○ Drug Addiction
○ Blood Clotting Disease	○ Mental Illness	○ Alcohol Addiction

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____ _____

Signature Date