

# North Shore Center for Orthopedic Surgery

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Normal Blood Pressure: \_\_\_\_\_

Present Orthopedic Problem: \_\_\_\_\_

Email address \_\_\_\_\_

Were you injured at work?  Yes  No

Were you injured in an auto accident?  Yes  No

## Medical History

Current or past medical problems \_\_\_\_\_

Have you ever had surgery? If so, what and when? \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications and Doses: \_\_\_\_\_

Pharmacy name and address: \_\_\_\_\_

Family History: If living, please state health. If deceased, please state cause of death and age at time of death

Father:  living  deceased

Mother:  living  deceased

Siblings:  living  deceased

Children:  living  deceased

Family History:  cancer  tuberculosis  diabetes  hemophilia  kidney disease  heart disease  
 allergy  arthritis  other \_\_\_\_\_

## Review of Systems: Do you have any of the following?

Nervous System:  Seizures  Passing Out Episodes  Migraines  Other: \_\_\_\_\_

Respiratory System:  Shortness of Breath  Congestion  Chest Pain  Spitting Up Blood

Cardiac:  Chest Pain  Fainting  Edema  Palpitations  Other: \_\_\_\_\_

Gastrointestinal:  Appetite  Nausea  Constipation  Diarrhea  Blood in Stool  Stomach  Hemorrhoids

Genitourinary:  Discharge  Frequency of Urination  Incontinence  Blood in Urine  Pain  Other: \_\_\_\_\_

Psychiatric:  Anxiety  Depression  Psychosis  Other: \_\_\_\_\_

Smoking:  Smoker (how long?) \_\_\_\_\_ (how much?) \_\_\_\_\_  
 Former Smoker (quit when?) \_\_\_\_\_  Non Smoker

Alcohol Consumption:  Never  Rare  Moderate  Heavy

Are you, or could you be pregnant?  Yes  No  Maybe

*I hereby authorize the release of any information required to complete my medical insurance payment directly to North Shore Center for Orthopedic Surgery for surgical or medical expenses. I understand that I am financially responsible for charges not covered by this authorization/referral.*

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or guardian, if patient is a minor

*By signing below, I acknowledge reading the office Privacy Policy and consent to their use and disclosure of my protected health information for treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where they have already made disclosures in reliance on my prior consent. I consent to treatment by \_\_\_\_\_*

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or guardian, if patient is a minor

**Co-Payment at Time of Service is Required**