CENTRAL ORTHOPEDIC GROUP, LLP
651 OLD COUNTRY ROAD
PLAINVIEW, NY 11803
516 681-8822

DATE _____DOCTOR_____PLV RVC MASS

NAME: _____DOB_____ ACCT# _____

BEST TELEPHONE CONTACT: _____ RELATIONSHIP:_____

IS THERE AN ADDRESS CHANGE: ____ YES ____ NO IF YES PLEASE WRITE BELOW:_____

_____Email:_____

HAS THERE BEEN ANY CHANGE IN YOUR MEDICAL INSURANCE? YES _____ (OR) NO _____

INSURANCE _____ ID # _____ POLICY HOLDER_____

____ YES ____ NO HAVE THERE BEEN ANY CHANGES IN YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT? IF YES, PLEASE DESCRIBE _____

_____

____ YES ____ NO HAVE YOU BEEN HOSPITALIZED OR ILL SINCE YOUR LAST VISIT? IF YES, PLEASE DESCRIBE:

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PHARMACY NAME: _____LOCATION:_____

____ YES ____ NO ARE YOU TAKING OR HAVE YOU TAKEN ANY MEDICINE REGULARLY NOT LISTED IN YOUR PREVIOUS HISTORY? (PREVIOUS HISTORY AVAILBLE UPON REQUEST) PLEASE LIST MEDICATIONS:_____

_____

____ YES ____ NO HAVE YOU DISCONTINUED ANY MEDICATION SINCE YOUR LAST VISIT. PLEASE LIST _____

_____

____ YES ____ NO ARE YOU HAVE ADDITIONAL DIFFICULTY OR ARE YOU EXPERIENCING SYMPTOMS RELATED TO THIS CONDITION SINCE YOUR LAST VISIT? PLEASE DESCRIBE:_____

_____

____ YES ____ NO HAVE YOU BEEN DIAGNOSED WITH ANY ALLERGIES NOT LISTED IN YOUR PREVIOUS HISTORY?

(PREVIOUS HISTORY AVAILABLE UPON REQUEST) PLEASE LIST:_____

____ YES ____ NO ARE YOU PREGNANT OR IS THERE ANY CHANCE OF YOU BEING PREGNANT? DESCRIBE:_____

_____

PATIENT SIGNATURE:_____PARENT /GUARDIAN SIGNATURE:_____

DOCTORS SIGNATURE: _____DATE:_____

**PLV RVC MASS**

**Patient History** FU / NI / NP DATE _____ MD _____ Account #_____

*Note: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.*

LAST NAME _____ FIRST NAME _____ MIDDLE_____

DATE OF BIRTH _____ AGE_____ RIGHT HANDED / LEFT HANDED/ AMBIDEXTROUS (CIRCLE ONE)

**CHIEF COMPLAINT:** WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)

_____

IS THIS WORK RELATED: YES/NO IS THIS CAR RELATED: YES/NO DATE OF INJURY: _____

DESCRIBE _____

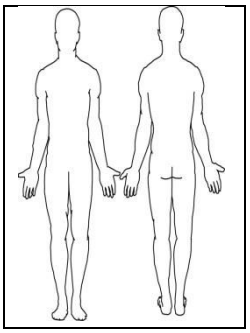
WERE XRAYS TAKEN YES / NO FACILITY _____ DATE _____ DO YOU HAVE FILMS YES / NO

WAS MRI/CT TAKEN YES / NO FACILITY _____ DATE _____ DO YOU HAVE FILMS YES / NO

WERE YOU TREATED IN THE HOSPITAL YES / NO URGENT CARE YES / NO ANOTHER DOCTOR YES / NO

NAME:_____ NAME:_____ NAME:_____

WHERE IS PAIN OR PROBLEM _____ RIGHT / LEFT_____MARK AREA AFFECTED--->



ON WHAT SCALE IS YOUR PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10 ( 0=NO PAIN 10 = EXTREME PAIN )

IS YOUR PAIN DULL/ SHARP/ ALWAYS THERE EXPLAIN_____

IS ANYTHING ELSE OCCURING AT THE SAME TIME? YES/ NO NAUSEA/ RASH /HEADACHE /OTHER_____

DOES THE PROBLEM INTERFERE WITH YOUR NORMAL FUNCTIONS _____

IS THERE ANYTHING THAT HELPS TO RELIEVE THE PAIN _____

**DOCTORS USE ONLY**

**DAILY ASPIRIN** YES / NO

**BLOOD THINNERS** YES / NO

**ORAL CONTRACEPTIVES** YES / NO

**POSSIBILITY OF BEING PREGNANT** YES / NO

**ALLERGIES: MEDS OR ENVIORNMENT**

_____☐ None

_____

_____

**MEDICATIONS** _____ ☐ None

_____

_____

_____

_____

_____

**MEDICAL PROBLEMS**_____☐ None

_____

_____

_____

_____

_____

# FAMILY AND SOCIAL HISTORY

LIST ANY SERIOUS ILLNESS IN YOUR IMMEDIATE FAMILY: CIRCLE ONE:

_____ RELATIONSHIP _____ DO YOU SMOKE YES OR NO

_____RELATIONSHIP_____ HOW MUCH _____

_____RELATIONSHIP_____ DO YOU DRINK YES OR NO

_____RELATIONSHIP_____ HOW MUCH _____

OCCUPATION: _____DO YOU LIVE ALONE YES OR NO

# REVIEW OF SYSTEMS

**DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS? CIRCLE CORRECT RESPONSE AND EXPLAIN IN SPACE PROVIDED**.

**CARDIOVASCULAR:** CHEST PAIN VARICOSE VEINS HYPERTENSION DEFIBRILLATOR PACEMAKER OTHER:_____ ☐ None

**CONSTITUTIONAL:** FEVER CHILLS HEADACHE OTHER:_____ ☐ None

**EYES:** BLURRED VISION DOUBLE VISION EYE PAIN OTHER:_____ ☐ None

**GASTROINTESTIONAL:** ABDOMINAL PAIN HISTORY OF ULCERS INDIGESTION/HEARTBURN NAUSEA/VOMITING
OTHER_____ ☐ None

**GENITOURINARY:** URINE RETENTION PAINFUL URINATION URINARY FREQUENCY OTHER:_____ ☐ None

**HEMATOLOGIC/LYMPHATIC:** BLOOD CLOTTING PROBLEM SWOLLEN GLANDS OTHER: _____ ☐ None

**INTEGUMENTARY:** SKIN RASH BOILS PERSISTENT ITCH OTHER: _____ ☐ None

**MUSCULOSKELETAL:** JOINT PAIN NECK PAIN BACK PAIN OTHER: _____ ☐ None

**NEUROLOGICAL:** TREMORS DIZZY SPELLS NUMBNESS / TINGLING OTHER: _____ ☐ None

**PSYCHOLOGICAL:** HISTORY OF DEPRESSION SLEEP DISTURBANCES ANXIETY DISORDER OTHER: _____ ☐ None

**RESPIRATORY:** WHEEZING FREQUENT COUGH SHORTNESS OF BREATH OTHER: _____ ☐ None

**PREVIOUS SURGERIES:** _____ ☐ None

_____

_____

X_____
SIGNATURE OF PATIENT /AUTHORIZED INDIVIDUAL

Date _____

VITALS TO BE COMPLETED BY MA
BMI _____
TEMP _____
HEIGHT _____
WEIGHT _____

**MA INITIAL _____**

PHYSICIAN _____DATE _____