TIER ORTHOPEDIC ASSOCIATES, P.C. 100 Plaza Drive, Vestal, NY 13850 Phone 607-798-9356

PATIENT/FAMILY MEDICAL HISTORY

Date **Birthdate** **Age** **SSN**

Name **Male** **Female**

Address **Telephone**

Occupation

Primary Care Physician/Referring Physician

Were x-rays brought with you? **Where taken?**

Nearest Relative **Relationship** **Phone**

CHIEF COMPLAINT

Why are you seeing the doctor today? ______________________________

Current problem is the result of a(n): Please check all that apply:

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other

Medication	Dose	Reason for Medication	Medication	Dose	Reason for Medication

Medication	Dose	Reason for Medication

ALLERGIC TO:

☐ Antibiotics, what: ______________________________

☐ Aspirin ☐ Codine ☐ Other ______________________________

Are all immunizations up to date? ☐ Yes ☐ No

If no, which immunizations are due? ______________________________

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	Circle		Describe all "Yes" responses
Eyes	No	Yes	
Ears, Nose, Throat	No	Yes	
Lungs, Breathing	No	Yes	
Chest Pain, Heart Problems	No	Yes	
Digestion	No	Yes	
Bowel movement	No	Yes	
Bladder problem	No	Yes	
Diabetes	No	Yes	
High blood pressure	No	Yes	
Bleeding problems	No	Yes	
Balance problems	No	Yes	
Numbness/tingling	No	Yes	
Blackout/fainting/seizure	No	Yes	
Psychological Problems	No	Yes	
AIDS	No	Yes	
Cancer	No	Yes	
Arthritis	No	Yes	
Polio	No	Yes	
TB	No	Yes	
Epilepsy	No	Yes	
Liver	No	Yes	
Hepatitis	No	Yes	
Kidney	No	Yes	

** PLEASE SEE OTHER SIDE **

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? ☐ **NO** ☐ **YES**

Have any problems with anesthesia? ☐ **NO** ☐ **YES**

Describe: ______________________________

FAMILY HISTORY (IMMEDIATE FAMILY ONLY):

Member	Alive	Deceased	Age	Health status or cause of death

Do any diseases run in your family-Describe:

SOCIAL HISTORY

☐ **Work in the home** ☐ **Employed (occupation ______________________)** ☐ **Student** ☐ **Daycare** ☐ **Retired**

☐ **Employed (occupation______________________)** **Currently Working** ☐ **Yes** ☐ **No**

Regular Duty ☐ **Yes** ☐ **No** **Restricted Duty** ☐ **Yes** ☐ **No** **If Yes, please state restrictions** ______________

Who took you out of work or put you on light duty? ______________

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Children? ☐ **No** ☐ **Yes #** ______________________

Do you live alone? ☐ **No** ☐ **Yes**

Exercise? ☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Rarely** ☐ **Never**

What type of exercise? ______________________________

History of substance abuse? ☐ **No** ☐ **Yes** **What?**

____

Smoke currently? ☐ **No** ☐ **Yes** _______ **Packs per day for** _______ **years.**

Quit smoking? ☐ **This year** ☐ **> 1 year** ☐ **> 5 years** ☐ **> 10 years** **Height:** _________ **Weight** _________

Previously smoked _______ **packs per day for** _______ **years.**

Drink alcohol? ☐ **Daily** ☐ **1-2 x/week** ☐ **1-2 x/month** ☐ **1-2 x/year**

INSURANCE MEDICAL RELEASE/ASSIGNMENT:

I hereby authorize release of medical information necessary to process my insurance claim, and I also hereby authorize payment directly to the physician for benefits due me for his services as described. I understand I am financially responsible for charges not covered by this authorization.

Patient Signature: ______________________________ ***Date:*** ______________

Reviewed by: ______________________________ ***, M.D.*** ***Date:*** ______________