NY ORTHOPEDICS

STEVEN J. LEE, M.D.

Initial Information

Name:_____ **DOB**:____/_____/_____**Occupation**:_____
Primary Care Physician (Name, Address, Phone Number):_____
_____
Pharmacy (Name & Address):_____
How did you hear about us? _____

Visit Information

Dominant Hand: ❑Right ❑Left
Reason for today's visit:_____
Symptoms the result of a work injury? ❑Yes ❑No **Auto Accident?** ❑Yes ❑No **School Injury?** ❑Yes ❑No
Start of symptoms: _____
What improves symptoms?_____
What worsens symptoms?_____
Prior treatment:_____
Current pain level (please circle): (*least severe*) **0 1 2 3 4 5 6 7 8 9 10** (*most severe*)

Medical History

Medical Conditions:_____
_____
Current Medications:_____
_____
Previous Surgeries:_____
_____
Drug Allergies (Include reaction): _____
_____
Family History (Include condition/relative):_____
_____

Social History

Alcohol use: ❑None ❑Occasionally ❑Daily ❑Heavy
Drug Use: ❑None ❑_____
Tobacco Use: ❑Never ❑Currently (packs per day: _____) ❑Former (Years: _____ to _____)

Review of Symptoms

Have you experienced any of the following over the past 6 months?

Fever/ Chills	❑Yes ❑No	Shortness of breath	❑Yes ❑No	Seizure	❑Yes ❑No
Blurred vision	❑Yes ❑No	Heartburn	❑Yes ❑No	Easy bleeding	❑Yes ❑No
Chest pain	❑Yes ❑No	Joint stiffness	❑Yes ❑No	Blood clot/DVT	❑Yes ❑No
Defibrillator	❑Yes ❑No	Skin rash	❑Yes ❑No	Nose bleeds	❑Yes ❑No
Stents	❑Yes ❑No	Loss of consciousness	❑Yes ❑No	Headaches	❑Yes ❑No
Pacemaker	❑Yes ❑No	Anesthesia complication	❑Yes ❑No	Diarrhea	❑Yes ❑No
Sleep Apnea	❑Yes ❑No	Constipation	❑Yes ❑No		

I certify that the above is correct and complete to the best of my knowledge.
Patient Signature: _____ Date: _____ Physician Signature: _____