



55 E 86<sup>TH</sup> ST, #1A  
NEW YORK, NEW YORK 10028  
(212) 348-3636

**MY APPOINTMENT TODAY IS WITH (PLEASE CHECK):**

- DONALD ROSE, MD
- THOMAS YOUIM, MD
- CRAIG CAPECI, MD
- MARTIN QUIRNO, MD

**PATIENT HISTORY**

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **EYES:** \_\_\_\_\_ **HAIR:** \_\_\_\_\_

**HANDED:** R L **SEX:** M F **RACE:** WH BL HIP ASIAN

**OCCUPATION:** \_\_\_\_\_ **SPORT:** \_\_\_\_\_

**CHIEF COMPLAINT:** \_\_\_\_\_

Neck\_ Arms: R L Back\_ Hip: R L Knee: R L Ankle: R L

**INJURY:** Y N **DATE:** \_\_\_\_\_ **WORK COMP**\_\_ **MVA**\_\_

**HISTORY:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAIN LOCATION:** Anterior\_\_ Posterior\_\_ Medial\_\_ Lateral\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PAIN FOR HOW LONG:** \_\_\_\_\_ **PAIN 1-10** \_\_\_\_\_

**PAIN:** Constant\_\_ Intermittent\_\_ Sharp\_\_ Dull\_\_ Night\_\_

Sitting\_\_ Stairs\_\_ Numbness/Tingling\_\_ Locking\_\_ Swelling\_\_

Giving Way\_\_ Clicking\_\_ Unstable\_\_ Other: \_\_\_\_\_

**WHAT MAKES PAIN BETTER:** \_\_\_\_\_

**WORSE:** \_\_\_\_\_

**TREATMENT:** None\_\_ PT\_\_ Injection\_\_ Meds\_\_ Rest\_\_ Ice\_\_

\_\_\_\_\_  
**Improved:** Y N

**XRAYS:**\_\_ **MRI:**\_\_ **CT:**\_\_ **EMG:**\_\_ **OTHER:** \_\_\_\_\_

**RESULTS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PRIOR SURGERY (dates):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**REVIEW OF SYSTEMS:** (any recent) Painful Urination\_\_

Fever/Chills\_\_ Blurred Vision\_\_ Shortness of Breath\_\_

Sore Throat\_\_ Chest Pain\_\_ Headaches\_\_ Weight Loss\_\_

Nausea/Vomiting\_\_ Rashes\_\_ Easy Bleeding/Bruising\_\_

Seizures\_\_ Explain: \_\_\_\_\_

**TOBACCO:** now\_\_ former\_\_ how many/day \_\_\_\_\_ yrs \_\_\_\_\_

**ALCOHOL** (drinks/wk) \_\_\_\_\_ **DRUGS** \_\_\_\_\_

**PREGNANT:** Y N **MARRIED:** S\_ M\_ D\_ W\_

**FAMILY HISTORY:** Diabetes\_\_ Heart Disease\_\_ Cancer\_\_

Hypertension\_\_ Stroke\_\_ Other: \_\_\_\_\_

**MEDICAL HISTORY:** Heart\_\_ Lung\_\_ Stomach\_\_ Diabetes\_\_

Hypertension\_\_ Liver\_\_ Kidney\_\_ Bladder\_\_ Sleep Apnea\_\_

Cardiac Stent\_\_ Blood Clot\_\_ Blood Thinner: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

**MEDS:** \_\_\_\_\_

\_\_\_\_\_

**ALLERGIES (meds):** \_\_\_\_\_

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**PT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_