ISLAND ORTHOPAEDICS AND SPORTS MEDICINE, P.C.
Medical and Surgical Information

PATIENTS NAME: _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ MALE ☐ FEMALE ☐

FAMILY PHYSICIAN NAME AND ADDRESS: _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

ARE YOU A: NEW PATIENT ☐ FORMER PATIENT OF DR CARROLL ☐
IF FORMER PATIENT, FOR WHAT PROBLEM AND WHEN:

SPECIFIC COMPLAINT TODAY: (Describe the area of discomfort and indicate side.)

IS THIS A **WORK RELATED** INJURY? YES ☐ NO ☐ **CAR ACCIDENT** YES ☐ NO ☐

DATE OF ONSET OR INJURY? _____

WHERE DID INJURY OCCUR? _____ HOW? _____

HAVE YOU BEEN TREATED FOR THIS COMPLAINT IN THE PAST? YES ☐ NO ☐

IF YES, EXPLAIN:

HAVE YOU HAD ANY X-RAYS OR OTHER TESTING DONE PERTAINING TO THIS INJURY?
SUCH AS CAT SCAN, MRI, BONE SCAN, ETC, IF SO WHERE AND WHEN?

RECENT MEDICAL ILLNESS

	YES	NO		YES	NO		YES	NO	
HEADACHE			BRONCHITIS			ANGINA			HEIGHT
VISUAL DISTURBANCE			DIARRHEA			DIABETES			WEIGHT
EARACHE			CONSTIPATION			ASTHMA			PREGNANT? YES ☐ NO ☐
HIGH BLOOD PRESSURE			HEART ATTACK			ULCER			B/P

HISTORY OF CANCER: (YOURSELF/FAMILY)

OTHER:

CURRENT MEDICATION:

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☐
IF SO PLEASE LIST AND WHAT REACTION YOU HAD AND WHEN:

HABITS: **ALCOHOL** YES ☐ NO ☐ **DRUGS** YES ☐ NO ☐ **SMOKING** YES ☐ NO ☐

RECENT HOSPITALIZATIONS:

PAST SURGERY:

SIGNATURE: _____ **DATE:** _____

REV 4/06