GREGG T. PODLESKI, D.O.

ORTHOPEDIC SURGERY • SPORTS MEDICINE • BOARD CERTIFIED
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HISTORY FORM

Please complete this form and bring it with you when you come to the office for your appointment.

NAME _____

DATE _____ **AGE** _____ **BIRTHDATE** _____

PRESENT ILLNESS:

1) For what condition or symptoms are you here for?

_____

2) When did the accident occur (or symptoms first came upon you)?

_____

3) In outline form, please try to give a chronological list or step by step history of the progression of symptoms from onset to present. When possible, record the approximate dates of important changes or developments.

_____

4) Is there any history of this or a similar problem prior to the current condition or symptoms?

_____

ORTHOPEDIC SCREEN: Please circle any of the following conditions you now have. Please underline any you have had in the past.

Rheumatism; recurrent joint swelling or pain; dislocated joints; loose body in joint; torn cartilage or ligaments; severely injured or sprained joints; known arthritic condition; gout or joint infection; joint laxity; loss of joint motion or other abnormality involving joints

Neck or back pain; ruptured disc or sciatica; spinal curvature or other spine abnormality; chest deformity

Brittle or soft bones; osteoporosis; known bone cyst or bone infection

Inherited or congenial abnormality of extremities, trunk or any other areas; amputations

Bursitis; tendonitis; painful bone spurs; torn muscles or tendons

Fractures and other serious injuries: Please list date and type:

_____

_____

_____

PAST HISTORY: If you have had any operations, please list them and indicate your age at the time of the procedure.

OPERATION	AGE

Please circle any of the following conditions you now have. Please underline any you have had in the past.

Heart trouble; high blood pressure; rheumatic fever; heart murmur; bladder or kidney trouble; diabetes; neurological disease; seizure disorder; tumor or cancer; respiratory illness; pneumonia or emphysema; tuberculosis; asthma; psoriasis or other skin disease; chronic alcoholism; drug addiction; stroke; phlebitis; peptic ulcer; anemia; blood disorder; bleeding problem; mental or nervous disorder; liver or gallbladder trouble; jaundice; thyroid disorder; colitis; tropical disease; genital or gynecological conditions; other than listed: _____

_____

ALLERGIES TO MEDICATIONS:

NAME OF MEDICATION	ADVERSE REACTION YOU EXPERIENCED

MEDICATIONS: Please list all medicines or drugs (including birth control medication) which you are taking now. Give dose and frequency. (If necessary, please check bottle label or consult pharmacist):

NAME OF MEDICATION	AMOUNT OR DOSE	FREQUENCY

BLOOD THINNERS: Are you currently taking any blood thinners over the counter or prescribed? NO YES, *if yes please list them below*

_____ _____ _____ _____ _____

Please indicate your approximate use or intake of the following:

Coffee _____ Tobacco Products _____ Alcoholic Beverages _____

Present Occupation: _____

Brief Job Description: _____

_____

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REVIEW OF SYSTEMS: Please circle any of the following symptoms or conditions you now have. Please underline any you have had in the past 6-12 months. If your symptom or condition is not on the list, please write it in.

GENERAL: Chills; fever; weight loss; weight gain; loss of appetite; other than listed: _____
_____

SKIN: Rashes; itching; sores; skin lesions; other than listed: _____
_____

EYE & VISION: Loss or change of vision; eye pain or redness; excessive watering; double vision; other than listed:_____

NOSE & THROAT: Hoarseness; excessive sneezing; blocked nasal passages; nosebleeds; frequent running nose; difficulty swallowing; other than listed: _____
_____

RESPIRATORY: Wheezing; large quantity of sputum; coughing up of blood; excessive cough; shortness of breath with little exercise or at night; night sweats; pain with breathing; other than listed: _____
_____

CARDIOVASCULAR: Chest pain; abnormal or fast heartbeat; abnormally low blood pressure; calf cramps with walking; excessive sensitivity of fingers and toes to cold; varicose veins; frequent and marked swelling of ankles and feet; other than listed: _____
_____

GASTROINTESTINAL: Digestion difficulties; nausea or vomiting; bloody vomitus; loss of appetite; abdominal pain; diarrhea or frequent loose bowel movements; blood in stool; hemorrhoids; gallbladder trouble; frequent or severe constipation; persistent anal itch; other than listed: _____
_____

GENITAL-URINARY: Urinary incontinence or dribbling; blood in urine; increased frequency of urination; urgency of urination; difficulty in starting or passing urine; painful urination; narrowing of urinary stream; flank pain; excess urine; other than listed: _____
_____

GENITAL-URINARY: (Male Patients) Penile pain, infection or sores; abnormality of testicles; scrotal swelling; varicocele; prostate gland abnormality; stricture; difficulty in sexual functioning; other than listed: _____
_____

GENITAL-URINARY: (Female Patients) Breast discharge, swelling, lumps, pain or infection: nipple changes or irritation; vaginal pain, infection discharge or itch; known uterine fibroids or tumors; tubal infections; abnormality of menstrual flow; painful menses; marked change in body hair distribution; date of last menstrual period (or menopause) _____; other than listed: _____
_____

Are you currently pregnant? Yes _____ No _____

NEUROLOGICAL: Severe or frequent headaches; unusual head or neck tension; dizziness; fainting spells; seizures or convulsions: shaking or twitching spells; paralysis of limbs; frequent or constant numbness or tingling of parts of body; severe lapses of memory; blackouts; other than listed: _____
_____

EMOTIONAL OR PSYCHOLOGICAL: Emotional illness; depression; recurrent feelings of loneliness or hopelessness; excessive worry; severe tension; feelings of worthlessness; recurrent fear; nervous exhaustion; frequent crying; insomnia; nervous breakdown; frequent nightmares; hysterical attacks; constant unhappiness; other than listed: _____
_____

OTHER MEDICAL OR SURGICAL CONDITIONS NOT ALREADY LISTED: (Include hospitalizations not previously noted). _____
_____
_____

Family History: (Check all that apply)

	Father	Mother	Brother	Sister	
Diabetes Mellitus	_____	_____		_____	_____
High Blood Pressure	_____	_____		_____	_____
High Cholesterol	_____	_____		_____	_____
Heart Disease	_____	_____		_____	_____
Lung Disease	_____	_____		_____	_____
Kidney Disease	_____	_____		_____	_____
Arthritis	_____	_____		_____	_____
Asthma	_____	_____		_____	_____
Stroke	_____	_____		_____	_____
Tuberculosis	_____	_____		_____	_____
Cancer	_____	_____		_____	_____

Site: _____

Other: _____

Family Member / Age
Living or cause of death

Father _____

Mother _____

Brothers _____

_____

_____

_____

_____

_____

Sisters _____

_____

_____

_____

_____

Attestation Statement
The undersigned attests that the above answers about the health history are true and correct. I will inform my physician of any changes that occur from this date forward. I will not hold the physician and/or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Authorization for Treatment
The undersigned authorizes the provider or provider selected by or on behalf of the patient whose name appears below to administer any treatment, procedures or diagnostic testing as may be deemed necessary or advisable. The treatment and procedures will be performed by physicians, physician assistants, nurse practitioners and employees of Pine Medical Group, P.C. and no guarantee of assurance has been made as to the results that may be obtained.

SIGNATURE _____ **DATE** _____

OTHER RESPONSIBLE PARTIES SIGNATURE _____ **RELATIONSHIP TO PATIENT** _____

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