

New York Orthopaedics and Sports Medicine, P.C.

Name _____ Age _____ Date of Birth _____

Home Address _____ Telephone _____

Business Name _____ Business Telephone _____

Business Address _____

Occupation _____ Referred By _____

Social Security # _____ Physician _____

Answer Yes or No?

Allergies _____ Insurance Information: Write Policy Number _____

Diabetes _____ Medicare _____

Hypertension (High Blood Pressure) _____

Ulcers _____ Blue Cross/Blue Shield _____

Arthritis _____ GHI _____

Cardiac Problems _____ Other Insurance _____

Bleeder _____

Kidney Disease _____ Spouse Name: _____ D.O.B. _____

Stroke _____ Social Security # _____

Malignancy _____ Insurance _____

Children _____

Operations _____

TO BE FILLED OUT BY PHYSICIAN BELOW:

VASCULAR

Color	R	L
Temp		
Edema		
Nutrition		
Hair		
Texture		
Burning		
Claudication		
Dorsalis Pedis		
Posterior Tibial		
Varicosities		
Nails		

NEUROLOGIC

Ankle Clonus	R	L
Tendo Achilles		
Patella		
Vibratory		
Babinski		
Parathesias		

Culture Reports

CHIEF COMPLAINT:

Onset-Duration

Past Therapy