ANDREW L ROSEN MD, FAAOS
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Personal Information

SSN: ______-_____-______ **First name:** ________________________ **MI:** ______ **Last name:** ____________________________

Prefix (Ms., Mr.): ________ **Sex:** M F **DOB:** ____/____/_____ **Marital status:** Single Married Divorced Widowed

Employment: Employed Unemployed Retired **Employer:** ____

Contact information

Street			Apt #
City	State	Zip Code	Country (if not US)
E-mail			
Home Phone	Work phone (with extension)	Mobile phone	

Who referred you to the practice? Referring physician or other source

Name	

Primary care physician / Family physician

Name		Phone number
Street		Fax number
City	State	Zip code

Emergency Contact information

Relation	First name	Last name
Home Phone	Work phone (with extension)	Mobile phone

Health Information Sharing

I authorize the person or persons below to release or disclose any information about my health care to medical personnel at Upper East Orthopaedics. I also authorize Upper East Orthopaedics to release medical information about my health care to the person or persons below.

Name of person(s) ____

Electronic Medication Prescribing

I authorize Upper East Orthopaedics to submit my medication prescriptions electronically to the pharmacy below. Please directly request the use of this service from your doctor or his assistants if desired.

Pharmacy

Name		
Street		
City	State	

Signature X ____ Date ____________________

Medical Information

Name	Age

History – Which body part? What are your symptoms? When did they begin?

Treatment - What physicians have you seen? What treatments have you had?

Occupation:____ **Height:** _____ **Weight:** _____

Regular exercise activities: ____

Which hand do you use to write? RIGHT LEFT

Do you smoke? YES NO If yes: Packs per day ________, Years smoked _________

How often do you drink alcohol? NEVER WEEKLY DAILY

Do you have any history of substance abuse? YES NO

Medical problems - To the best of your knowledge, have you ever been diagnosed with any of the following conditions? *Please circle one for each.*

High blood pressure	**YES**	**NO**
Heart disease	**YES**	**NO**
Lung disease	**YES**	**NO**
Cancer	**YES**	**NO**
Diabetes	**YES**	**NO**
Liver disease	**YES**	**NO**
Hepatitis	**YES**	**NO**
Bladder or kidney problems	**YES**	**NO**
HIV positive or AIDS	**YES**	**NO**

Sexually transmitted diseases	**YES**	**NO**
Tuberculosis	**YES**	**NO**
Immune disorders	**YES**	**NO**
Epilepsy or stroke	**YES**	**NO**
Thyroid disease	**YES**	**NO**
Blood disorders	**YES**	**NO**
Skin rashes or disorders	**YES**	**NO**
Osteoporosis	**YES**	**NO**
Psychological problems	**YES**	**NO**

If you answered YES to any of the above, please describe below.

Operations - Please list all with dates

Medications - Please list all that are taken regularly

Allergies to medicines - Please list all

Family history - List any medical problems of close blood relatives (parents, siblings, children)