Alice Chen, MD/IP CT, LLC.
Hospital for Special Surgery
1 Blachley Rd~Stamford, CT 06902
(203) 705-2087-Office (877)-363-0849-Fax

OFFICE USE ONLY
Date: _____
MR#:_____

Patient Information Clinical Form

Name: _____ Sex: M or F Date of Birth: _____ Age: _____

CHIEF COMPLAINT

Reason for today's visit – please list your symptoms in order of severity and how long you had symptoms:

_____

_____

Who has been treating you for this problem: _____

What type of treatments have been given for problem: _____

Have you had any Scans, X-rays or MRIs done: _____ If yes, where?_____

Current problem is a result of: **CHECK ALL THAT APPLY**

___ Car Accident ___ Work Accident ___Other: _____

Explain: _____

Have you ever had similar symptoms in the past? No Yes, explain: _____

_____

REVIEW OF SYSTEMS

Have you ever had any of the following conditions: **CHECK ALL THAT APPLY**

General:
- ☐ Weight loss (unintentional)
- ☐ Unexplained fever
- ☐ Night sweats

HEENT (HEAD):
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing loss
- ☐ Balance problems/Dizziness
- ☐ Frequent sinus problems
- ☐ Frequent sore throat

Neuro/muscular:
- ☐ Low back pain
- ☐ Leg pain/numbness/weakness
- ☐ Neck pain
- ☐ Arm pain/numbness/weakness
- ☐ Frequent headache/migraine
- ☐ Seizures
- ☐ Problem with memory
- ☐ Difficulty with speech
- ☐ Confusion
- ☐ Double or blurred vision
- ☐ Neurological illness (MS, ALS, Parkinson's, etc.)
- ☐ Stroke/TIA

Cardiovascular (HEART):
- ☐ Heart attack
- ☐ Chest pain or angina
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart murmur
- ☐ Irregular heart beat
- ☐ Swelling of feet or hands
- ☐ Date of Last EKG/stress test

_____

Respiratory (LUNGS):
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Shortness of breath at rest
- ☐ Bloody sputum
- ☐ Recent pneumonia
- ☐ Chronic cough
- ☐ Sleep apnea
- ☐ Oxygen use

Gastrointestinal (DIGESTIVE):
- ☐ Frequent nausea/vomiting
- ☐ Blood in vomit or stools
- ☐ Liver disease
- ☐ Jaundice
- ☐ Ulcer or gastritis
- ☐ Esophageal reflux (GERD)
- ☐ Disease of the colon
- ☐ Constipation/Diarrhea
- ☐ Frequent Stomach pain

Genitourinary:
- ☐ Recent bladder infections
- ☐ Blood in urine
- ☐ Urinary frequency/urgency
- ☐ Incontinence
- ☐ Prostate disease
- ☐ Kidney disease

Endocrine (GLANDS):
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Hormone problems

Hematological/Immune (BLOOD):
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Immunological disorders (Lupus, RA, HIV/AIDS, etc)

Psychological:
- ☐ Depression/anxiety/bipolar

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Comments/Additional explanations from the section above:

_____

_____

PAST MEDICAL HISTORY

Please circle any conditions you have been treated for:

High Blood Pressure Heart Disease High Cholesterol Congestive Heart Failure Heart Attack
Stroke Diabetes Asthma/COPD/Emphysema Thyroid Disease
Neurological disease: _____
Other: _____
_____

Surgeries/Hospitalizations	**YEAR**

Have you ever had problems with anesthesia? No Yes - If yes please describe:

_____

ALLERGIES:

Medication: _____Reaction: _____
Medication: _____Reaction: _____
Medication: _____Reaction: _____
Medication: _____Reaction: _____
Other allergies:_____

MEDICATIONS:

Please list all medications you are taking, including over the counter medications, such as: aspirin, Tylenol, Advil, Aleve, herbal preparations, etc.
Are you taking anything to thin your blood? **Yes No**
Med: _____ _____mg. - times taken _____
Med: _____ _____mg. - times taken _____
Med: _____ _____mg. - times taken _____
Med: _____ _____mg. - times taken _____

Name of doctor(s) prescribing medications:

_____ _____
_____ _____

Are you currently being treated by any other doctor besides your primary care doctor?
Yes No (If yes, please list their names below and specialty, i.e. cardiologist, etc)

Physician Name: **Specialty**

_____ _____
_____ _____
_____ _____

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FAMILY MEDICAL HISTORY

Please list any **immediate relatives** (parents, brother/sister, grandparents, and children) who have/had the following:

Heart disease/Heart attack: _____ High blood pressure: _____
Stroke:_____ Diabetes:_____
Cancer (what type?):_____ Neurological disorders: _____
Other: _____

SOCIAL HISTORY

Occupation: _____ usual activities required: _____

Do you have children? No Yes How many? _____ Do they live with you? _____

Are you exclusively responsible for anyone's care? No Yes, Who? _____

Do you have anyone to help you at home if you have surgery? No Yes, Who? _____

Do you smoke? ___ No, I have never smoked.

___ Yes, I have smoked ____ packs of cigarettes a day for ____ years

___ No, I quit smoking ___ yrs. ago, I smoked ___ packs a day for ___ yrs

___ Yes, I smoke cigars or a pipe, ____ a day for ____ yrs

Do you drink alcohol? ___ No

___ Yes, _____ drinks a day week month

Do you use any street drugs? ___ No, never

___ Yes, please list: _____

Please answer the following question with regard to possible future testing:

	YES	NO	N/A
Are you pregnant?	___	___	___
Are you claustrophobic?	___	___	
Are you a welder/metal worker?	___	___	
Have you worked with metal in the past?	___	___	

Please circle any of the following that you have: Cardiac pacemaker - Cardiac valve prosthesis – Vena cava umbrella - Automated internal cardiac defibrillator - Nitroglycerin patch - Aneurysm clip - Neurostimulator - Implanted pump - any metal in your body

The information provided on this form is accurate to the best of my knowledge.

_____ _____

Patient Signature *Date*

I have reviewed the above information with the patient.

_____ _____

Dr. Chen's Signature Date