

**STEPHEN FEALY, MD**  
**HOSPITAL FOR SPECIAL SURGERY**  
**DEPARTMENT OF SPORTS MEDICINE & SHOULDER SERVICE**  
**523 EAST 72<sup>ND</sup> STREET, 2<sup>ND</sup> FLOOR**  
**212-606-1894**

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Email address: \_\_\_\_\_

Referring doctor (if any): \_\_\_\_\_

Why are you seeing the doctor?:

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How long has this problem existed? \_\_\_\_\_

Is the problem a result of:

\_\_\_\_\_ sports injury

\_\_\_\_\_ work injury

\_\_\_\_\_ accident

\_\_\_\_\_ fall \_\_\_\_\_ lifting \_\_\_\_\_ pulling

\_\_\_\_\_ hit by object \_\_\_\_\_ squatting

What have you done for this problem to date?

Medicine: \_\_\_\_\_

Physical therapy: \_\_\_\_\_

Injections (steroid shot): \_\_\_\_\_

Surgery: \_\_\_\_\_

How many days a week do you engage in sports or work out? \_\_\_\_\_

What type of exercise do you do? \_\_\_\_\_

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Do you smoke? \_\_\_\_\_ # of packs? \_\_\_\_\_

Do you drink? \_\_\_\_\_ # of drinks? \_\_\_\_\_ day/week/mo

Do you have a history of substance abuse? \_\_\_\_\_

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Medical History: Are you currently having or have you had problems with:

	YES	NO	Type
• Asthma/ lungs	_____	_____	_____
• High blood pressure	_____	_____	_____
• Heart disease	_____	_____	_____
• Digestion	_____	_____	_____
• Bleeding problems	_____	_____	_____
• High cholesterol	_____	_____	_____
• Immune deficiency	_____	_____	_____
• Difficulty urinating	_____	_____	_____
• Cancer	_____	_____	_____
• Diabetes	_____	_____	_____
• Sleep Apnea	_____	_____	_____

Any family members with similar orthopaedic history or experiences?

\_\_\_\_\_  
\_\_\_\_\_

Do you take any medications?

\_\_\_\_\_  
\_\_\_\_\_

Previous surgery:

\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_

Do you have any allergies to medications?

Medicine: \_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_

Other allergies (type): \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_