Central Jersey Sports Medicine & Orthopaedic Center, P.C.
Andrew Harrison, M.D.
Keeping you active and raising the level of play!

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Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name:_____ Date: _____

Primary Physician:_____ Telephone #:_____

Pharmacy: _____ **Chief Complaint:**_____

History of Present Illness:

* Location_____
(Where is the pain/problem?)
* Severity_____
(How severe is the pain on a scale of 1-10)
(10 being the most severe)
* Timing _____
(Does this pain/problem occur at a specific time? Constant vs Often)
* Quality_____
(Example:Burning, sharp, aching, etc.)
* Duration_____
(How long have you had this pain/problem, or when did it start? Date or # of days/months)
* Context_____
(Where were you at the onset of this pain/problem?)

Medical History

* Past Medical History

Diabetes	No	Yes
Hypertension/High BP	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart Trouble	No	Yes
Arthritis	No	Yes
Convulsions/Seizures	No	Yes
Bleeding tendency	No	Yes
Asthma/Lung problems	No	Yes
Ulcers	No	Yes
Kidney/Liver Problems	No	Yes
High/Low Cholesterol Disease	No	Yes
High/Low Thyroid Disease	No	Yes

Any Other medical conditions not listed above?
_____

Allergies to Medication?
_____
_____
_____

Latex Allergy:
Yes No

Medications you currently are taking: Reason for Medication:
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

* Do you have an advanced directive / living will?
NO YES
If yes, where is it kept? _____

Please List **ANY & ALL** Previous Surgeries/Hospitalizations/Serious injuries :
_____
_____

Patient Social History:

Use of alcohol: Never:___ Past:___ Rarely:___ Moderate:___ Daily:___
Use of tobacco: Never:___ Previously, but quit:___ Current packs/day____
Use of drugs: Never:___ Past:____ Current:____ Type/Frequency:_____

Family Medical History:

	Disease	Deceased
Father	_____	Yes____ No____
Mother	_____	Yes____ No____

CENTRAL JERSEY SPORTS MEDICINE & ORTHOPAEDIC CENTER, PC

Review of Systems: Please indicate any personal history below:

CONSTITUTIONAL SYSTEMS:
Negative / Fever / Chills / Sweats / Weakness / Fatigue / Decreased Activity / Other:_____

EYES:
Negative / Recent Visual Problem / Iceterus / Discharge / Blurring / Double vision / Visual Disturbances /
Other:_____ ____

EARS,NOSE,MOUTH,THROAT:
Negative / Decreased hearing / Ear pain / Nasal Congestion / Sore throat / Other:_____

RESPIRATORY (LUNGS):
Negative / SOB / Cough / Sputum production / Hemoptysis / Wheezing / Cyanosis / Apnea / Asthma
Other:_____

CARDIOVASCULAR:
Negative / Chest Pain / Palpitations / Bradycardia / Tachycardia / Peripheral edema / Syncope /
Other:_____

GASTROINTESTINAL:
Negative / Nausea / Vomiting / Diarrhea / Constipation / Heartburn / Abdominal pain / Hematemsis /
Other:_____

GENITOURINARY:
Negative / Dysuria / Hematuria / Change in urine stream / Urethral discharge / Lesions / Pregnant: __Y __N
Date of last period:_____Other:_____

HEMATOLOGIC/LYMPHATIC:
Negative / Brusing tendency / Bleeding / Tendency / Swollen lymph glands / Other:_____

ENDOCRINE:
Negative / Excessive Thirst / Polyuria / Cold Intolerance / Heat intolerance / Excessive hunger /
Other:_____

IMMUNOLOGIC:
Negative / Immunocompromised / Recurrent fevers / Recurrent infections / Malaise / Other:_____

MUSKULOSKELETAL:
Negative / Back Pain / Neck pain / Joint pain / Muscle pain / Caludication / Decreased rang of motion / Trauma /
Other:_____

INTEGUMENTARY:
Negative / Rash / Pruritus / Abrasions / Breakdown / Burns / Dryness / Petechiae / Hypertrophic scar / Keloid /
No other significant skin complaints / Other:_____

NEUROLOGIC:
Negative / Alert & oriented / Abnormal / Balance / Confusion / Numbness / Tingling / Headache /
Other:_____

PSYCHIATRIC:
Negative / Anxiety / Depression / Mania / Suicidal / Delusional / Hallucinations /
Other:_____