☐ **DONALD J. ROSE, M.D.** ☐ **THOMAS YOUM, M.D.** ☒ **CRAIG M. CAPECI, M.D.**

Name: ☐ 1056 5th Ave, NY, NY 10028

Chart #: ☐ 1095 Park Ave, NY, NY 10128

Visit Date: ☐ 263 7th Ave, Ste. 2B, Bklyn, NY 11215

PATIENT HISTORY

Patient's Name: ____ ***Date of Birth:*** ______________________

Chief Complaint *(main problem)* **1.** ____

Other complaints: **2.** ______________________________ **3.** __________________________________

Neck Arms R L Back Hips R L Knees R L Ankles R L Feet R L

History of Present Illness *(What happened?)* ***Date of Injury:*** ______________________

____

____

____

Did the problem result from an injury or accident? ___________ If so, explain ______________________

____

Location of pain ____ Pain on a scale 1-10 ____________

Is the pain: Constant _____ Sharp _____ Dull _____ At night _____ Other ______________________

Review of Systems: Have you had any of the following recently?

Fever/Chills _____ Blurred Vision _____ Shortness of Breath _____ Sore Throat _____

Chest Pain _____ Nausea/Vomiting _____ Painful Urination _____ Rashes ______

Easy Bleeding/Bruising _____ Seizures _____ Headaches _____ Weight Loss ______

Allergies: __________________________________ ***Drug Allergies:*** ____________________________

Social Hx: Occupation ________________________ Tobacco ______ Alcohol _______ Drugs ________

Height ___________ Weight ___________ Eyes __________ Hair ___________ Handed: R L

Recreational Sports/Exercise? _______ If so, which ones? ______________________________

Family Hx: DIABETES HEART DISEASE CANCER HYPERTENSION BLOOD CLOTS

If parent(s) deceased, underlying condition? Mother _______________ Father ______________

Medical Hx: HEART HYPERTENSION DIABETES LUNGS GASTROINTESTINAL

OSTEOPENIA VASCULAR DISEASE LIVER KIDNEY BLADDER

If so, explain:____

____

Prior Surgery (with dates): ____

____

____

Current Medications: ____

____

Are you taking blood thinners? _______ COUMADIN ASPIRIN PLAVIX Other:_______________

Signature of Patient ____________________________________ Date ______________________

Physician's Notes:

Signature of Physician ________________________________ Date ______________________