**Patient Account#_____**

Patient Name: _____ DOB: _____ Date: _____

# Ashley C. Cogar, M.D.

***Orthopedic Specialist for Hand/Wrist/Elbow***

## Chief Complaint / Reason For Visit Summary

**What body part / extremity are you being seen for today? _____ RT / LT / BOTH**

**How long have you had this injury**: _____

**OFFICE USE:**

Height _____ Weight _____ BP: _____ Pulse: _____

**Are you experiencing pain today? No If yes, how would you rate your pain on a scale of 1-10? _____**

**What is your dominant hand?** Right Handed Left Handed Ambidextrous

**Is this injury a work-related injury?** □ Yes □ NO

If yes, date of accident / injury: _____ has a claim been filed for this injury? _____

**Is this injury due to a Motor Vehicle Accident?** □ Yes □ NO

If yes, date of accident / injury: _____ has a claim been filed for this injury? _____

**Please describe how you sustained your injury:**

_____

_____

_____

_____

**Please tell us about any other primary concerns you have that you would like to discuss with Dr. Cogar during your visit today.**

**Office Use Only:**

**Entered By: _____ Date Entered: _____**

**Patient Account#_____**

Patient Name: _____ DOB: _____ Date: _____

# Ashley C. Cogar, M.D.

## *Orthopedic Specialist for Hand/Wrist/Elbow*

## Medical History Form

**Review of Systems**

Are you experiencing any of the following symptoms?

**General:**
- □ Chills
- □ Excessive Weight Gain/Loss
- □ Fatigue
- □ Fever
- □ Night Sweats
- □ Weakness

**Skin:**
- □ Discoloration
- □ Easy Bruising
- □ Hives
- □ Jaundice
- □ Rash

**HEENT:**
- □ Dizziness
- □ Lightheadedness
- □ Visual Changes
- □ Hearing Problems
- □ Ringing in the Ears
- □ Postnasal Drainage
- □ Sinus Pressure
- □ Snoring
- □ Hoarseness
- □ Sore Throat

**Respiratory:**
- □ Cough
- □ Coughing Up Blood
- □ Shortness of Breath
- □ Wheezing

**Cardiovascular:**
- □ Chest Pain
- □ Difficulty Breathing on Exertion
- □ Palpitations
- □ Swelling of Extremities

**Gastrointestinal:**
- □ Abdominal Pain
- □ Constipation
- □ Diarrhea
- □ Difficulty Swallowing
- □ Food Intolerance
- □ Nausea
- □ Vomiting

**Genitourinary:**
- □ Blood in Urine
- □ Frequency
- □ Groin Pain
- □ Incontinence
- □ Pelvic Pain
- □ Urgency

**Musculoskeletal:**
- □ Back Pain
- □ Joint Pain
- □ Muscle Pain
- □ Muscle Weakness
- □ Numbness
- □ Stiffness

**Neurologic:**
- □ Headaches
- □ Memory Loss
- □ Seizures
- □ Syncope
- □ Tingling
- □ Tremor
- □ Weakness

**Psychiatric:**
- □ Anxiety
- □ Depression
- □ Trouble Focusing

**Endocrine:**
- □ Excessive Thirst
- □ High Blood Sugar
- □ Low Blood Sugar

**Hematology:**
- □ Abnormal Bleeding
- □ Enlarged Lymph Nodes

**Office Use Only:**

**Entered By: _____ Date Entered: _____**

**Patient Account#_____**

Patient Name: _____ DOB: _____ Date: _____

## Past Medical History

Heart
- □ Heart Attack
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol
- □ Irregular Heart Beat
- □ Atrial Fibrillation
- □ Other_____
  _____

Stomach
- □ Reflux
- □ Heartburn
- □ Ulcers
- □ Bleeding
- □ Irregular Bowel
- □ Diverticulitis
- □ Liver Disease
- □ Hepatic Failure
- □ Other_____

Endocrine
- □ Diabetes Type I
- □ Diabetes Type II
- □ Gestational Diabetes
- □ Thyroid
- □ Other_____
  _____
  _____
  _____

Lungs
- □ Asthma
- □ COPD
- □ Emphysema
- □ Other_____
  _____

Musculoskeletal
- □ Arthritis
- □ Gout
- □ Broken Bones
- □ Other_____
  _____

Neurologic
- □ Stroke
- □ Headache
- □ Migraine
- □ Dementia

Dermatology
- □ Skin Cancer
- □ Acne
- □ Rash

Urology
- □ Kidney Stones
- □ Prostate Issues
- □ Other_____

Gynecology
- □ Endometriosis
- □ HPV

Psychiatric
- □ Memory Loss/Confusion
- □ Anxiety
- □ Depression
- □ Bipolar

Other
- □ Anemia
- □ Sinus & Allergy
- □ Other_____
  _____

- □ Cancer: List What Type
  _____
  _____
  _____

## Social History

Tobacco:

□ Never

□ Current: Cigarettes □ No □ Yes Amount:_____pack(s)/day
Smokeless Tobacco □ No □ Yes Amount:_____per day
Cigars □ No □ Yes Amt:_____# per week

□ Quit: Year last smoked _____ Amt: _____pack/day How many years did you smoke?_____

Children: Secondhand smoke exposure? □ Yes □ No

Alcohol use: □ Yes □ No _____# drinks per day / week / occasional / social *(please circle)*

Occupation: _____

**Office Use Only:**

**Entered By: _____ Date Entered: _____**

**Patient Account#_____**

Patient Name: _____ DOB: _____ Date: _____

## Family History

Have any of your family members had any of the following problems?

| | | | | |
|---|---|---|---|---|
| ☐ Alcoholism | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Asthma | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Breast Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Colon Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Depression | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Diabetes | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Elevated Lipids | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Heart Attack | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Heart Disease | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ High Blood Pressure | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Lung Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Migraines | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Osteoporosis | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Ovarian Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Prostate Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Skin Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Stroke | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Thyroid Disease | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Uterine Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Other Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Other Diagnosis | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |
| ☐ Other Mental Illness | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_____ |

List all **ALLERGIES** to any medications **and** the reactions:

☐ **No Known Drug Allergies**

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Office Use Only:**

**Entered By: _____ Date Entered: _____**

**Patient Account#_____**

Patient Name: _____ DOB: _____ Date: _____

Immunizations:
Flu Vaccine: Date: _____ NO
Pneumonia Vaccine: Date: _____ NO
Covid: Date:_____ NO

**CURRENT MEDICATIONS:** (Please include over the counter medication and food supplements.)

□ **None**
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____

## Past Surgical History

**Please check or list all of the SURGERIES you have had:**

| Type of Surgery | Year |
|---|---|
| □Appendectomy | |
| □Arthroscopy (joint) | |
| □ Back Surgery or □ Neck Surgery | |
| □Cataract Surgery | |
| □Cesarean Section | |
| □Gallbladder Removal | |
| □Heart Surgery (Specify) | |
| □Hemorrhoids | |
| □Hernia (Specify) | |
| □Hysterectomy | |
| □ Knee Replacement or □ Hip Replacement | |
| □Mastectomy or Lumpectomy (Specify) | |
| □Polyp Removal (Colon) | |
| □Tonsillectomy or □ Adenoidectomy | |
| □Tubal Ligation or □ Vasectomy | |
| □Plastic Surgery (Specify) | |
| □Other (Specify) | |
| □Other (Specify) | |

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**Patient Account#_____**

Patient Name: _____ DOB: _____ Date: _____

**Have you had any radiology procedures (ex: Xray, MRI, CT scan) specific to the reason you are here today?** □ NO □ Yes *(Please list)*

| Radiology Procedure | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

What is your preferred pharmacy (Please include name and phone number): _____

_____

What is your preferred mail order pharmacy (Please include name and phone number): _____

_____

**Office Use Only:**

**Entered By: _____ Date Entered: _____**