

# Howard J. Gelb, M.D., P.A., F.A.A.O.S

Board Certified and Fellowship Trained in Sports Medicine & Orthopaedic Arthroscopic Surgery  
9980 Central Park Blvd. North, Suite 222, Boca Raton, FL 33428 Phone: 561.558.8898 Fax: 561.558.8868

(Please Print) – Please fill out completely as much as possible

Name (First): \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last): \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Gender: \_\_\_\_\_ Right handed: \_\_\_\_\_ Left handed: \_\_\_\_\_ Ambidextrous: \_\_\_\_\_

Occupation: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Who is your Primary Doctor or Pediatrician? \_\_\_\_\_ Phone number: \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS

Describe the condition that brought you to this office: \_\_\_\_\_

Is your injury:  Work Accident  Auto Accident  Slip and Fall  Sports Related  Other injury Related

Date when Accident/Injury occurred: \_\_\_\_\_ How long have symptoms been present: \_\_\_\_\_

Description of Accident/Injury: \_\_\_\_\_

Where did the Accident/Injury occur? \_\_\_\_\_

Contributing events or cause for symptoms: \_\_\_\_\_

Describe the severity and quality of pain: (sharp, dull, stabbing, etc.) \_\_\_\_\_

Circle rating of 1-10 for severity of symptoms with 10 being the greatest: 1 2 3 4 5 6 7 8 9 10

Frequency of symptoms:  constant  intermittent  daily Duration of symptoms:  constant  hours  minutes  seconds

Do symptoms include?  swelling  weakness  numbness  decreased motion  pins and needle sensation Other: \_\_\_\_\_

If applicable, is the joint?  popping  locking  clicking  instability/giving way Other: \_\_\_\_\_

What activities worsen your condition? \_\_\_\_\_

When do the symptoms occur?  morning  afternoon  evening  during exercise  after exercise

Have you been previously treated for this accident/injury elsewhere? \_\_\_\_\_ If yes, by whom? \_\_\_\_\_

Past treatment of your current problem:  ice treatment  heat treatment  physical therapy  rest (length of time)  injections (how many?) \_\_\_\_\_

medications  related past surgeries for condition (specify procedure and date) \_\_\_\_\_

Do you have an attorney?  If yes: Attorney's Name: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_

Attorney's Number: \_\_\_\_\_

\*\*\*\*\*WORK-RELATED INJURIES PLEASE COMPLETE THE FOLLOWING: \*\*\*\*\*

Are you still working? \_\_\_\_\_

Have you had a prior or similar work injury? \_\_\_\_\_

Can you do modified work at this time? \_\_\_\_\_ If yes, what type of work activities can you perform? \_\_\_\_\_

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

### PAST MEDICAL HISTORY – Check all that apply

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Leukemia        | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Hiatal hernia        |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Drug Addiction  | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Gout                | <input type="checkbox"/> HIV                  |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Liver disease        |
| <input type="checkbox"/> Other: _____        | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Psoriasis      | <input type="checkbox"/> Peptic Ulcer        |   |
| <input type="checkbox"/> Cancer (type) _____ |  |   |  |   |

### PAST SURGICAL HISTORY – Check all that apply

- |   |   |  |  |  |
|---|---|--|--|--|
| <input type="checkbox"/> Appendectomy   | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Heart Bypass            | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Skin Cancer Surgery |
| <input type="checkbox"/> Arthroscopy    | <input type="checkbox"/> Carpal Tunnel    | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Neck Surgery      | <input type="checkbox"/> Tonsillectomy       |
| <input type="checkbox"/> Back Surgery   | <input type="checkbox"/> C-Section        | <input type="checkbox"/> Hernia Repair           | <input type="checkbox"/> Pacemaker         | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Gall Bladder     | <input type="checkbox"/> Hysterectomy            | <input type="checkbox"/> Prostate Surgery  |  |

### ALLERGIES

- |                                       |                                  |                                  |                                 |                                    |                               |
|---------------------------------------|----------------------------------|----------------------------------|---------------------------------|------------------------------------|-------------------------------|
| <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Novacaine | <input type="checkbox"/> Tape |
| <input type="checkbox"/> Other: _____ |                                  |                                  |                                 |                                    |                               |

### MEDICATIONS

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

### FAMILY HISTORY

- |           |                                |                                   |            |   |
|-----------|--------------------------------|-----------------------------------|------------|---|
| Father :  | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Mother:   | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Brother : | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Sister :  | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Son:      | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Daughter: | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |

### SOCIAL HISTORY

- |                   |                                       |  |                                       |                                     |                                   |  |
|-------------------|---------------------------------------|--|---------------------------------------|-------------------------------------|-----------------------------------|--|
| Primary Language: | <input type="checkbox"/> English      | <input type="checkbox"/> Spanish         | <input type="checkbox"/> French       | <input type="checkbox"/> Portuguese | Other: _____                      |  |
| Marital Status:   | <input type="checkbox"/> Single       | <input type="checkbox"/> Engaged         | <input type="checkbox"/> Married      | <input type="checkbox"/> Divorced   | <input type="checkbox"/> Widow    |  |
| Alcohol Use:      | <input type="checkbox"/> None         | <input type="checkbox"/> Rare            | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Socially   | Other: _____                      |  |
| Smoking History:  | <input type="checkbox"/> Non-Smoker   | <input type="checkbox"/> Previous Smoker | Packs per day? _____                  | How long? _____                     |                                   |  |
|                   |                                       | <input type="checkbox"/> Current smoker  | Packs per day? _____                  | How long? _____                     |                                   |  |
| Sports:           | <input type="checkbox"/> Football     | <input type="checkbox"/> Baseball        | <input type="checkbox"/> Basketball   | <input type="checkbox"/> Soccer     | <input type="checkbox"/> Hockey   | <input type="checkbox"/> Rollerblading |
|                   | <input type="checkbox"/> Karate       | <input type="checkbox"/> Skating         | <input type="checkbox"/> Golf         | <input type="checkbox"/> Tennis     | <input type="checkbox"/> Swimming | <input type="checkbox"/> Cheerleading  |
|                   | <input type="checkbox"/> Running      | <input type="checkbox"/> Wrestling       | <input type="checkbox"/> Lacrosse     | <input type="checkbox"/> Dance      | <input type="checkbox"/> Jujitsu  | <input type="checkbox"/> Snow-skiing   |
|                   | <input type="checkbox"/> Snow-skiing  |  |                                       |                                     |                                   |  |
|                   | <input type="checkbox"/> Other: _____ |  |                                       |                                     |                                   |  |

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

**REVIEW OF SYSTEMS - (Please check all that apply)**

**Constitutional:**

- Weight gain
- Weight loss
- Fever
- Chills
- Fatigue

**Eyes:**

- Blurred vision
- Cataracts
- Need glasses for reading
- Contact lens
- Glaucoma
- Double vision

**Ears, Nose, Throat**

- Hearing loss
- Dry mouth
- Nasal congestion
- Sore Throat
- Tinnitus
- Dentures
- Dental work
- Jaw pain
- Loose teeth

**Cardiovascular**

- High blood pressure
- Chest pain
- Shortness of breath
- Dyspnea on exertion
- Angina
- Palpitations
- Intermittent Pain in lower legs or thighs
- Coolness of hands
- Blood Clots
- Swelling, edema
- Cyanosis

**Respiratory**

- Cough
- Difficulty breathing
- Wheezing
- Asthma treatment
- Emphysema
- Sputum production
- Blood in sputum

**Genitourinary**

- Burning on urination
- Blood in urine
- Difficulty voiding
- Urgency
- Frequency
- Flank pain
- Kidney stones
- History of UTI

**Gastrointestinal**

- Diarrhea
- Blood in stool
- Nausea
- Vomiting
- Ulcers
- Food intolerance

**Musculoskeletal**

- Joint pain
- Locking
- Swelling
- Giving way
- Partial giving way
- Loss of motion
- Pain with motion
  
- Decreased ability to walk
- Difficulty tying shoes
- Difficulty climbing stairs
- Difficulty sitting
- Difficulty standing
- Back pain
- Neck pain
- Shoulder pain
- Hip pain
- Knee pain
- Ankle pain
- Wrist pain
- Elbow pain
- Hand pain
- Joint stiffness
- Foot pain in morning
- Joint warmth
- History of Orthopedic Surgery

**Integumentary**

- Skin lesions
- Rash
- Redness of skin
- Moles
- Dry or Scaly skin
- Nail problems

**Neurological**

- Numbness
- Seizures
- Balance problems
- Tingling
- Dizziness
- Blackouts
- Migraines
- Headaches
- Difficulty walking
- Bowel or Bladder loss of control

**Psychiatric**

- Depression
- Anxiety
- Nervousness
- Insomnia
- History of psychiatric problems
- Addiction
- Drug use

**Endocrine**

- Hunger
- Thirst
- Frequent urination
- Hair loss
- Night sweats
- Weight loss
- Weight gain

**Hematological/Lymphatic**

- Bleeding problems
- Swelling
- History of Leukemia
- Anemia
- AIDS
- Cancer

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## PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment payment of health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information, (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objection to this form please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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