

# EMKEY ARTHRITIS AND OSTEOPOROSIS CLINIC

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## NEW PATIENT HISTORY FORM

Name: \_\_\_\_\_ Date of first appointment: \_\_\_/\_\_\_/\_\_\_

Spouse/Significant Other: Alive/Age: \_\_\_\_\_ Deceased/Age: \_\_\_\_\_

Education (Circle highest level attended): Grade school High School College Graduate School

Occupation: \_\_\_\_\_ # of hours worked per week (average): \_\_\_\_\_

Referred by (check one):  Self  Family  Friend  Doctor  Web  Other

Name Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Do you have an orthopedic surgeon?  Yes  No If yes, name: \_\_\_\_\_

Briefly describe your present symptoms: \_\_\_\_\_

\_\_\_\_\_

Date symptoms began (approximate): \_\_\_/\_\_\_/\_\_\_ Diagnosis: \_\_\_\_\_

Previous treatment for this problem (include: physical therapy, surgery, medications and injections):

\_\_\_\_\_

Please list the name(s) of other practitioner(s) you have seen for this problem: \_\_\_\_\_

\_\_\_\_\_

**Medical History** (please list all medical problems for which you have been diagnosed and treated):

\_\_\_\_\_

\_\_\_\_\_;

\_\_\_\_\_;

\_\_\_\_\_;

**Surgical History** (please list all previous operations, name of hospital, reason for surgery and approximate dates):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

