Richard Gellman, M.D.

Name: _____ DOB: _____

Problem/Injury: _____

Date of Injury:_____ Primary Care Physician: _____

Right: _____ Left: _____ Both: _____ Employer: _____

Name of Referring Doctor: _____ Occupation: _____

Were you treated in the E.R.? _____ Name of Hospital: _____

Describe how injury occurred: _____

_____

List all medical conditions: Height: _____ Weight: _____

Diabetes: _____ High Blood Pressure: _____ Chronic Pain: _____ Hepatitis: _____ HIV: _____

Liver Failure: _____ Kidney Failure (*dialysis*): _____ Dialysis Schedule: _____

Congestive Heart Failure: _____ Other: _____

_____

_____

Previous Surgeries: _____

_____

Do you smoke cigarettes? Yes / No If yes, how many per day? _____

Do you drink alcohol? Yes / No If yes, how many per day? _____

Medications: _____

_____

Allergies to Medications: _____

_____

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