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Patient Information Sheet

1. Referring Physician: Name:

Address:

Phone:

2. Chief Complaint (what problem brings you in today?):

3. History of your Main Complaint:

4. Previous Treatments?

Medications Surgery Physical Therapy Injection Brace

Other _____

5. Past Medical History (Any medical problems?):

Diabetes High blood pressure High Cholesterol Heart Attacks

Strokes Osteoporosis Rheumatoid Arthritis Blood clots

Other _____

6. Past Surgical History (Any surgery in the past?):

7. Allergies:

8. Current Medications:

Tony Quach, MD _____

9. Social History:

- Do you smoke? Yes No If yes, how much per day?
- Do you drink alcohol? Yes No If yes, how much per day?
- Occupation
- Marital Status Children?

10. Family History of Medical Problems: If yes, explain

- Father: Yes No
- Mother: Yes No
- Grandparents: Yes No
- Siblings: Yes No

11. Any Medical Problems in the following areas?

- Con weight loss loss of appetite fevers chills
- GI heart burn nausea, vomiting bloody stools liver disease
- Eyes blurred vision double vision vision loss
- ENT hearing loss hoarseness trouble swallowing
- CV chest pain palpitations blood clots
- Pulm chronic cough shortness of breath
- GU kidney problems blood in urine painful urination
- Endo thyroid disease heat intolerance cold intolerance
- Skin rashes skin ulcers lumps psoriasis
- Neuro headaches dizziness seizures
- Psych depression drug/alcohol addiction sleep disorders
- Heme anemia easy bleeding easy bruising
- ID HIV hepatitis