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Dr. Daniel Troy
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(Please Complete)

Name: _____ Age: _____ Date: _____
Occupation: _____ Height: _____ Weight: _____
Name of the referring physician? : _____
Why were you referred here? : _____
Area affected? (E.g. right hand, left knee): _____ Hand Dominance? : _____ R _____ L
Date of injury? : _____ Type of injury? Auto: ☐ Work: ☐ Other: _____
How long have you had this present condition? :_____
Have you been treated for this condition before? Yes: ☐ No: ☐ If yes, list treatment so far:
_____
_____

Do you have any of the following diseases?

YES	NO		YES	NO	
☐	☐	Asthma or Emphysema	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Bleeding Problem
☐	☐	Thyroid Disease	☐	☐	Heart Problem
☐	☐	High Blood Pressure	☐	☐	Kidney Problem
☐	☐	Liver Problems (Jaundice, Hepatitis)	☐	☐	Stomach Ulcer
☐	☐	Respiratory Disease	☐	☐	Seizure Disorder
☐	☐	Family History of Anesthesia Problems	☐	☐	Cancer (Self Only)
☐	☐	Family History of Bleeding Problems	☐	☐	Pacemaker

Please list <u>all medications</u> you are taking:

Medications	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **allergic** to any medications? Yes: ☐ No: ☐ If yes, what? : _____
Do you smoke? Yes: ☐ No: ☐ Former: ☐ Years? _____ How Much? _____
Do you drink excessive **alcohol**? Yes: ☐ No: ☐
Do you use illicit drugs? Yes: ☐ No: ☐ If yes, what? :_____
Surgeries:
_____
_____

Patient's Signature: _____ **Date:** _____