Baylor Scott & White
ORTHOPAEDIC CONSULTANTS OF NORTH TEXAS
A member of HealthTexas Provider Network

Anil Koganti, M.D.

Date:_____

Height: _____ft ____ in
Weight: _____ lbs

Patient Name: _____**DOB:** _____

History of Present Illness

What problem(s) are you being seen for today? _____
_____
Referring Doctor:_____ _____
Primary Care Physician (If different):_____ _____
When did this problem arise? _____
Was this an injury/ accident? Yes No Work-related? Yes No Auto Accident ? Yes No
Date of Injury? _____ Hand Dominance: Right or Left
How did your symptoms begin? _____
Treatments received thus far:
□ Anti-inflammatory medication □ Brace □ Other: _____
□ Physical therapy □ Injection _____

Allergies to Medications:

□ None identified	□ Metal Allergy

Current Medications (Name and dosage) **□ None**

Preferred Pharmacy:_____ **Pharmacy Phone:**_____

Surgical History

Ankle Surgery	Yes No	Hand Surgery	Yes No	Shoulder Surgery	Yes No
Back Surgery	Yes No	Heart Surgery	Yes No	Spinal Fusion	Yes No
Carpal Tunnel Release	Yes No	Hip Surgery	Yes No	Spine Surgery	Yes No
Elbow Surgery	Yes No	Knee Athroscopy	Yes No	Wrist Surgery	Yes No
Foot Surgery	Yes No	Knee Surgery	Yes No		Yes No
Other Surgical History	Yes No		Yes No		Yes No
If "Yes," please explain:					

Medical History

Alcoholism	Yes No	Fractures	Yes No	Inflammatory Arthritis	Yes No
Anesthetic Complications	Yes No	Gout	Yes No	Kidney disease	Yes No
Arthritis	Yes No	Heart Disease	Yes No	Liver disease	Yes No
Autoimmune Disease	Yes No	Hep C	Yes No	Lung Disease	Yes No
Cancer	Yes No	HIV/AIDS	Yes No	Osteoporosis	Yes No
Clotting Disorder	Yes No	Hyperlipidemia	Yes No	Smoking	Yes No
Deep Vein Thrombosis	Yes No	Hypertension	Yes No	Stroke	Yes No
Diabetes Mellitus	Yes No	Infectious Disease	Yes No	Thyroid Disease	Yes No
If "Yes," please explain:					

Patient Name:_____

Family History

	Anesthesia Problems	Arthritis	Cancer	Clotting Disorder	Diabetes Mellitus	Deep Vein Thrombosis	Gout	Heart Disease	Hyperlipidemia	Hypertension	Thyroid Disease	Lung Disease	Osteoporosis	Ovarian Cancer	Hepatitis	HIV	Liver disease	Autoimmune disease	Kidney disease	Stroke
Mother																				
Father																				
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				
Other Details:																				

Social History

Do you smoke? Yes No Packs/day?_____ Smokeless varieties_____
How many years have you or did you smoke? _____ When did you quit? _____
Do you drink alcohol? Yes No How much? □Daily □____/week
Marital History: M S D W
Occupation _____ Employer_____
Are you currently working? Yes No If not, how long have you been off?_____

Review of Systems

Do you have any complaints of:						□None of the following/No to all	
Chest Pain	□	Constipation	□	Abnormal Bleeding	□	Abnormal Menstrual Cycle	□
Cough	□	Cold Hands/Feet	□	Growth Disturbance	□	Incontinence of Bowel	□
Depression	□	Loss of Appetite	□	Runny Nose	□	Incontinence of Urine	□
Ear Pain	□	Muscle Weakness	□	Numbness of Feet	□	Sleep Disturbance	□
Fainting	□	Impotence	□	Numbness of Hands	□	Sputum Production	□
Fever	□	Balance Problems	□	Shortness of Breath	□	Visual Disturbance	□
Mania	□	Seizures	□	Sore Throat	□	Swelling in the Legs	□
Skin Rash	□	Skin Ulcers	□	Wheezing	□	Unexplained Weight Loss	□
Vomiting	□	Stomach Pain	□	Weight Gain	□	Other _____	