Advanced Orthopaedic centers

Appointment Date: _____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Marital status: _____ Religious Preference: _____ Gender: _____

Referring Physician: _____

Address: _____ Phone: _____

Referring Physician's Fax: _____ Email: _____

Primary Care Physician: _____

Address: _____ Phone: _____

Primary Care Physician's Fax: _____ Email: _____

Pharmacy phone number: _____

Insurance Carrier:

1. _____ ID#: _____

2. _____ ID#: _____

Claim Adjustor (if applicable): _____ Phone: _____

If you are not the insured, what relation are you to the insured? ☐ Spouse ☐ Child

If you are not the insured, what is the insured's DOB? _____

Nearest Relative (relationship): _____ Phone: _____

Address: _____

Are Your Employed: ☐ Yes ☐ No Occupation: _____

If employed, how long? _____ If unemployed, how long? _____

Is this due to pain? ☐ Yes ☐ No

Do you plan to go on disability? ☐ Yes ☐ No

Please list your medical problems, other than pain (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illness, etc):

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all your current medications with dosages:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all your medications with dosages for pain management in the past:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list any allergies to medication: _____

Please list any intolerance to medications: _____

Please list any prior surgeries not related to pain, and dates performed:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list any prior surgeries related to pain (such as laminectomy) and dates performed:

1. _____

2. _____

3. _____

Family Medical History:

1. _____

2. _____

3. _____

4. _____

5. _____

With whom do you live? _____

Are there any substance abuse issues in your household? ☐ Yes ☐ No If yes, please explain: _____

_____

Are you able to care for yourself? ☐ Yes ☐ No If no, please give caregiver's name & phone number:

_____

Are you currently involved in lawsuit? ☐ Yes ☐ No If yes, please explain: _____

_____

Where is your pain? Be specific and list in order of most severe to least severe:

1. _____ Most severe

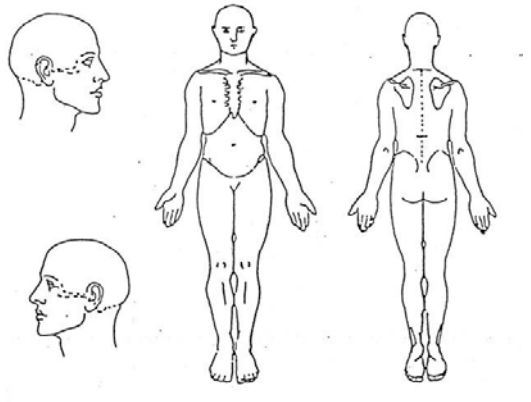
2. _____

3. _____

4. _____

5. _____ Least pain

Please mark where your pain is located:



When did your pain start? _____

Was there a particular event that caused your pain? ☐ Yes ☐ No Please explain: _____

How often does your pain occur and for how long? _____

What makes your pain worse? _____

What makes your pain better? _____

	Date	Facility	Results
☐ X-rays	_____	_____	_____
☐ CAT Scan	_____	_____	_____
☐ MRI	_____	_____	_____
☐ EMT	_____	_____	_____
☐ Myelogram	_____	_____	_____
☐ Other	_____	_____	_____

Please list any other doctors you have consulted regarding this problem:

	Name	Specialty	Date	Phone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Please check off any treatments you have undergone for this problem, and if they helped or not helped your problem:

	Helped Yes	Helped No		Helped Yes	Helped No
☐ Surgery	☐	☐	☐ Chiropractor	☐	☐
☐ Medication	☐	☐	☐ Ultrasound	☐	☐
_____			☐ Acupuncture	☐	☐
_____			☐ Biofeedback	☐	☐
_____			☐ Hypnosis	☐	☐
☐ Nerve block, steroid or trigger point injection	☐	☐	☐ Relation	☐	☐
☐ Bed Rest	☐	☐	☐ Exercise	☐	☐
☐ TENS	☐	☐	☐ Traction	☐	☐
☐ Other	☐	☐	☐ Heat	☐	☐

Pain can be very difficult to describe. It is helpful to compare the intensity of your pain at different intervals. Please rate the intensity of your pain on a scale of 0 to 10. 0 = no pain 10 = the worst pain you can imagine

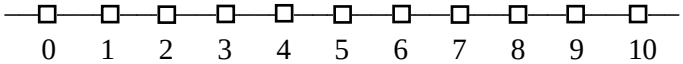
What is your pain now? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What is your level of pain when it is most severe? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What is your level of pain when it is least painful? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

On subsequent visits, we will refer to the 0 to 10 pain scale and ask you to rate your pain.

Please mark an “X” on the line to represent the intensity of your pain.



0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

Advanced Orthopaedic centers

MEDICAL HISTORY (Check answer(s) that apply) PATIENT NAME: _____

1. Constitutional Symptoms ☐ No Problems
☐ weight loss _____lbs., period of time _____
☐ weight gain _____lbs., period of time _____
☐ recurrent fever
☐ general weakness
☐ fatigue – persistent

2. Skin ☐ No Problems
☐ dry skin
☐ recurrent rashes
☐ eczema
☐ itching
☐ changes in skin color
☐ changes in hair or nails

3. Hematologic/Lymphatic ☐ No Problems
☐ swollen glands
☐ low blood count (anemia)
☐ easy bruising
☐ easy bleeding
☐ slow to heal after cuts
☐ history of blood transfusion
☐ enlarged glands
☐ phlebitis
☐ HIV positive
☐ on blood thinners

4. Head/Face ☐ No Problems
☐ headaches/migraines
☐ history of head injury – no residual problems
☐ history of head injury with residual problems of _____
☐ facial pain
☐ TMJ ☐ R ☐ L
☐ Tic douloureux ☐ R ☐ L

5. Eyes ☐ No Problems
☐ nearsighted
☐ farsighted
☐ wear glass
☐ wear contact lenses
☐ cataracts at present time ☐ R ☐ L
☐ conjunctivitis ☐ R ☐ L
☐ glaucoma ☐ R ☐ L
☐ double vision
☐ blurred vision

6. Ear/Nose/Mouth

Ears ☐ No Problems
☐ hard of hearing ☐ R ☐ L
☐ hearing aids ☐ R ☐ L
☐ frequent earaches ☐ R ☐ L
☐ chronic ear discharge ☐ R ☐ L
☐ vertigo
☐ ringing in ears ☐ R ☐ L

Nose/Sinuses ☐ No Problems
☐ sinus discharge
☐ nasal discharge
☐ repeated nosebleeds
☐ deviated nasal septum
☐ chronic sinus problems
☐ chronic stuffy nose
☐ hay fever
☐ nasal polyps

Mouth/Throat ☐ No Problems
☐ teeth _☐_ loose _☐_ none
☐ dentures _☐_ full _☐_ partial
☐ bleeding gums
☐ dry mouth
☐ sore throat
☐ hoarseness
☐ vocal cords polyps
☐ trouble swallowing

7. Chest / Breasts ☐ No Problems
☐ breast masses
☐ breast surgery
☐ chest surgery
☐ other explain: _____

8. Respiratory ☐ No Problems
☐ smoker ___ pack(s) per day since _____

MEDICAL HISTORY (Check answer(s) that apply) PATIENT NAME: _____

- ☐ recurrent cough
- ☐ chronic bronchitis
- ☐ sarcoidosis
- ☐ emphysema
- ☐ chronic obstructive pulmonary disease
- ☐ bronchial asthma
- ☐ tuberculosis
- ☐ wheezing

9. Cardiac / Peripheral – Vascular

Cardiac ☐ No Problems

- ☐ heart trouble
- ☐ swelling of the feet
- ☐ high blood pressure
- ☐ chest pain
- ☐ heart attack
- ☐ bypass surgery
- ☐ angioplasty
- ☐ mitral valve prolapse
- ☐ heart murmur
- ☐ valvular surgery
- ☐ heart failure
- ☐ shortness of breath with walking

Peripheral - Vascular ☐ No Problems

- ☐ poor circulation in arm ☐ R ☐ L
- ☐ blood clots in arm ☐ R ☐ L
- ☐ varicose veins ☐ R ☐ L
- ☐ poor circulation in legs ☐ R ☐ L
- ☐ blood clots in legs ☐ R ☐ L
- ☐ vascular surgery _____

10. Hepatic – Biliary/Gastrointestinal/Abdominal

- ☐ any liver disease
- ☐ history hepatitis ___☐__ Active ___☐__ Inactive
- ☐ history jaundice due to gallbladder disease
- ☐ gallbladder problems

Gastrointestinal ☐ No Problems

- ☐ loss of appetite
- ☐ abdominal pain
- ☐ problem with gas
- ☐ heartburn
- ☐ recurrent nausea
- ☐ recurrent diarrhea
- ☐ recurrent constipation
- ☐ ulcer
- ☐ hiatal hernia
- ☐ regurgitation
- ☐ reflux
- ☐ indigestion
- ☐ history of vomiting blood
- ☐ loss of control of bowels
- ☐ bleeding ulcers
- ☐ diverticular disease
- ☐ Chron's disease

11. Urinary ☐ No Problems

- ☐ frequent urination
- ☐ difficulty with urination
- ☐ burning on urination
- ☐ inability to control urination
- ☐ loss of control
- ☐ blood in urine
- ☐ kidney stones

12. Genitalia / Reproductive

Male ☐ No Problems

- ☐ discharge
- ☐ painful testicles
- ☐ lumps in testicles
- ☐ hydrocele
- ☐ sexually transmitted disease(s)
- ☐ sexual dysfunction

Female ☐ No Problems

- ☐ menstruation ☐ Regular ☐ Irregular
- ☐ first day of last menstrual period ___/___/___
- ☐ premenstrual syndrome, since _____
- ☐ recurrent vaginal discharge
- ☐ number of pregnancies ___ miscarriages ___ abortions ____
- ☐ Caesarian section(s), number _____
- ☐ on hormones
- ☐ history cancer of uterus - ovaries
- ☐ sexual dysfunction
- ☐ sexually transmitted disease(s)

13. Endocrine ☐ No Problems

- ☐ excessive thirst or urination
- ☐ heat intolerance

MEDICAL HISTORY (Check answer(s) that apply) PATIENT NAME: _____

- ☐ cold tolerance
- ☐ change in hat or glove size
- ☐ thyroid trouble ☐ Underactive ☐ Overactive
- ☐ sugar diabetes-since _____
  Insulin dependent ☐ Yes ☐ No
- ☐ disease of pituitary gland
- ☐ disease of adrenal gland
- ☐ Cushing's disease

14. Muscoloskeletal ☐ No Problems

- ☐ muscle cramps
- ☐ stiff joints
- ☐ swelling joints
- ☐ generalized arthritis
- ☐ rheumatoid arthritis
- ☐ fibromyalgia syndrome
- ☐ osteoporosis
- ☐ neck pain
- ☐ upper back pain
- ☐ low back pain
- ☐ heel spurs
- ☐ gout
- ☐ difficulty with walking
- ☐ cold upper extremities ☐ R ☐ L
- ☐ cold lower extremities ☐ R ☐ L
- ☐ pain in feet

15. Neurological / Psychiatric

Neurological ☐ No Problems

- ☐ frequent or recurrent headaches
- ☐ fainting
- ☐ migraines
- ☐ blackouts
- ☐ stroke
- ☐ dizzy spells
- ☐ gait difficulties
- ☐ seizures
- ☐ epilepsy
- ☐ tremors
- ☐ neuropathy
- ☐ weakness
- ☐ paralysis

Psychiatric ☐ No Problems

- ☐ problems with concentration
- ☐ confusion
- ☐ problems with thinking or thought process
- ☐ problems with memory
- ☐ depression
- ☐ anxious
- ☐ shaky
- ☐ agitated

16. Allergies / Immunologic

Allergies ☐ No Problems

- ☐ drug allergies _____ _____
- ☐ food allergies _____ _____
- ☐ environmental allergies _____ _____

Immunologic ☐ No Problems

- ☐ Immunologic disorders
- ☐ AIDS
- ☐ lupus