

Patient Name: _____ Date: ____/____/____

Age ____ Height _____ Weight _____ Male Female Right Left Handed

Onset: Date of injury- or -Onset of symptoms: ____ / ____ / ____

Please describe the specific orthopaedic problem for which you are being evaluated today? Rt/ Lt

How did this occur?

Is this a: Motor Vehicle Accident Liability case Work Injury Sports Other:

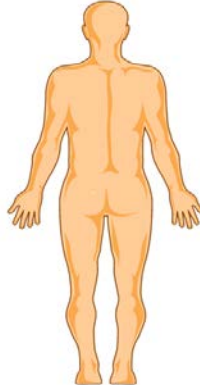
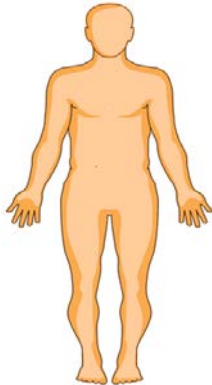
Job Title & Specific Duties:

Working now? Yes No (if not, why):

Utilizing the Diagram below, please indicate the location and side of your pain:

Front

Back



Describe the quality/intensity of pain (select on from each category):

- dull throbbing sharp
- mild moderate severe

Is your pain constant? Yes No

Does it come & go? Yes No

Since symptoms began has pain:

- Improved Worsened No Change

Right

Left

Left

Right

Duration and frequency of your pain?

What improves it? (eg. rest, cold, limb elevation):

What worsens it? (eg. activities or position):

Does it radiate/move to other locations? **Where?**

When is your pain the worst? Morning Afternoon Evening Awaken from Sleep

Have you had any: Locking Giving away Bruising Numbness Tingling Redness Warmth
 Swelling Fever Or any other symptoms?

Have you: Injured this area before?

Had X-rays or other tests done? **Where?** **When?**

Hospitalization or **Surgery** for this problem? **Where?** **When?**

Therapy or **splinting**?

Do you use a? cane crutches walker

Any **other** orthopaedic problems?

Have you or a relative had treatment here before?

If you are being seen for a BACK problem: Have you had any change in or problems with:

Bowel/bladder control Yes No Sexual function Yes No

Current Medical Problems:

Past Surgeries:

List all Current Medications:

LIST ALL ALLERGIES to Food or Medication:

Any **Family History** of heritable musculoskeletal or connective tissue disorders? No Yes

REVIEW OF SYSTEMS: Do you have any problems with the following: Check Yes or No

Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blackouts/Fainting/Balance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ears/Nose/Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychological	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lungs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart/Circulation/Vascular	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach/Heartburn/Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio/TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis/Liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney/Bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergic/Immunological	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin/Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood/Bleeding Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prednisone/Steroid Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes/Thyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Clots (legs-lungs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (please explain)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explain all marked with a "YES" answer:

Do you smoke? Yes No Packs/day: _____ **Drink Alcohol?** Yes No Drinks per day: _____

Please list hobbies/special interests:

What activities does your current condition prevent you from?

Name of Doctor requesting consultation:

Primary Doctor Name/Location:

Attorney for this problem Yes No Name/Address:

How often do you exercise? Daily Weekly Monthly Rarely Never

Marital status Married Single Separated Divorced Widowed

Do you have children? Yes No How many? _____ Do you live alone? Yes No

Patients signature: _____ Date: / /

Reviewed By: _____ **MD** **Date:** / /

Physical exam: Temperature: _____ Pulse: _____ BP: _____

**The Orthopaedic Group, LLC
Patient Information Form**

Patient: _____ Birthdate: _____ SS# _____ - _____ - _____

Address: _____ City: _____ ST _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Primary Doctor: _____ Address: _____ Phone: _____

Employer: _____ Address: _____

Spouse Name: _____ Birthdate: _____ SS# _____ - _____ - _____

Spouse Employer: _____ Phone: _____

Next of Kin not living with you: _____ Phone: _____

Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY: (If you are legal guardian or if patient is a minor or student)

Name: _____ Address: _____

INSURANCE INFORMATION:

PRIMARY: _____ ID# _____ GRP# _____

Who subscribes to insurance: _____ Birthdate: _____

SECONDARY: _____ ID# _____ GRP# _____

Who subscribes to insurance: _____ Birthdate: _____

If your Insurance plan requires a *written referral* from your primary doctor, one must be obtained BEFORE the appointment or you will be rescheduled- NO EXCEPTIONS

SIGNATURE REQUIRED-PLEASE READ:

As per your contract and ours with your insurance company, copays are due at the time of visit and are not billable. There will be no exceptions, so please be prepared to pay at time of check in.

Regardless of any insurance coverage I/we may or may not have, it is my/our responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I/we agree to pay costs and attorney fees as allowable by law and acknowledge receipt of this agreement. I give authorization to release my medical records for billing purposes.

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS ONLY, Please read & sign:

I request that payment under the Medicare/Metrahealth insurance program be made directly to The Orthopaedic Group, LLC on any bills for services rendered by their physicians during my lifetime. I understand that I may be held responsible for a portion of these bills after Medicare has paid the provider, or for charges Medicare does not cover.

SIGNATURE: _____ DATE: _____