Orthopedic Surgery Specialists

INTAKE QUESTIONNAIRE

Patient Name: _____ Date of Birth: ___/___/___ Appt Date: ___/___/___

Office Use Only:
Age:_____
Ht:_____
Wt:_____
Temp:_____
BMI:_____

Reason for Visit: _____

When did your pain begin (approximate date): _____

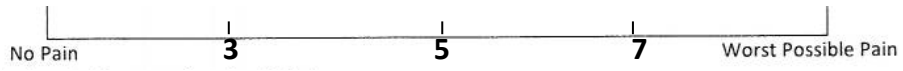
Where is your pain located? _____

Have you had this pain before? If yes, when? _____

Is it getting better, getting worse, or neither? _____

What type of pain is it: Dull? Throbbing? Sharp? Burning? Numbness/Tingling? Other: _____

Please indicate with an "X" on the line below the level of pain you are experiencing:



How did your pain start: (Please check all that apply)

☐ Suddenly ☐ Cut/Laceration ☐ Gradually ☐ Pulling
☐ Gradually ☐ Fall ☐ Twisting ☐ Other: _____

What activities make your pain worse: (Please check all that apply)

Hands/Upper Extremity: ☐ Gripping/Pinching ☐ Typing/Writing ☐ Reaching over head ☐ Driving

Lower Extremity/Other:

☐ Exercise ☐ Lifting ☐ Standing ☐ Bending ☐ Twisting ☐ Sitting ☐ Walking
Other: _____

What activities reduce your pain: (Please check all that apply)

☐ Brace ☐ Rest ☐ Straightening out arms
☐ Heat/Ice ☐ Exercise ☐ Other: _____

What medications are you currently taking for this pain? _____

What treatments have you tried for this pain: (Please check all that apply)

☐ Physical/Hand therapy ☐ Chiropractor ☐ Acupuncture ☐ Home Exercises ☐ None

Have you been seen for this pain by any of the following: (Please check all that apply)

☐ MD/NP/PA: _____ ☐ Hospitalized (date): _____ ☐ None
☐ Emergency Room (date): _____ ☐ Urgent Care Center (date): _____

Have you had any of the following tests/studies: (Please check all that apply)

☐ X-ray (date): _____ ☐ CT Scan (date): _____ ☐ Other: _____
☐ MRI (date): _____ ☐ Nerve Study (date): _____ ☐ None

Have you had surgery for this pain or similar pain: ☐ No ☐ Yes, when: _____

Physician Signature: _____

Orthopedic Surgery Specialists
REVIEW OF SYSTEMS – MEDICAL HISTORY

Patient Name:_____ **DOB:**____/____/____ **Appt Date:**____/____/____

PCP:_____ **Phone #** _____ **Pharmacy:**_____ **Phone #**_____

Referring Doctor:_____

Please complete the following form as completely as possible in blue or black ink.

PAST MEDICAL HISTORY: (Please check all that apply)

- ☐ Glaucoma
- ☐ Cataract
- ☐ Hypertension
- ☐ Rheumatic Fever
- ☐ Reflux
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Mitral Valve Disease
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Emphysema/COPD
- ☐ Stroke
- ☐ Seizures
- ☐ Migraines
- ☐ Psychiatric
- ☐ Staph Infection
- ☐ Peptic Ulcers
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ STD
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ DVT/Blood Clots
- ☐ Rejected Implant
- ☐ Broken Bone
- ☐ Rheumatoid Arthritis
- Cancer: _____
- ☐ Other: (please describe) _____

PAST SURGICAL HISTORY: (Please check all that apply)

- ☐ Gallbladder
- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Amputation
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Hernia Repair
- ☐ Joint Surgery
- ☐ CABG
- ☐ Heart Stent/Surgery
- ☐ Pacemaker
- ☐ Neck/Back
- ☐ Other: (please describe) _____

ALLERGIES: (Help us decide if a true allergy or just an intolerance)

- ☐ Penicillin; reaction: _____
- ☐ Iodine; reaction:_____
- ☐ **NONE**
- ☐ Sulfa; reaction:_____
- ☐ Codeine; reaction:_____
- ☐ Other medications; reactions:_____

MEDICATIONS: (Please list all medications you are taking, the dosages, and how often OR attach full medication list)

Medication	Dosage	Frequency

☐ **List attached**

REVIEW OF SYMPTOMS: (Please check all that apply)

- ☐ Weight loss
- ☐ Weight gain
- ☐ Recent Infections
- ☐ Muscle weakness
- ☐ Bleeding/bruising
- ☐ Eyes/Vision
- ☐ Mood changes
- ☐ Appetite changes
- ☐ Swelling
- ☐ Genital numbness
- ☐ Chest pain
- ☐ Night sweats
- ☐ Arm numbness
- ☐ Joint pain
- ☐ Handwriting changes
- ☐ Shortness of breath
- ☐ Fever
- ☐ Leg numbness
- ☐ Difficulty walking
- ☐ Fatigue
- ☐ Stiffness
- ☐ Rashes
- ☐ Cough
- ☐ Nausea/Vomiting
- ☐ Ulcers
- ☐ Nighttime pain
- ☐ Emphysema
- ☐ Abdominal pain
- ☐ Difficulty with buttons
- ☐ Bowel incontinence
- ☐ Other:(please describe) _____

FAMILY HISTORY: (Please check all diseases diagnosed in your blood relative)

- ☐ Rheumatoid Arthritis
- ☐ Inflammatory Bladder Disease
- ☐ Anesthesia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart
- ☐ Hypertension
- ☐ Lipids
- ☐ Psychiatry
- ☐ Stroke
- ☐ Thyroid
- ☐ Emphysema
- ☐ Neurologic Disease
- ☐ Other: (please describe) _____

SOCIAL HISTORY: (Please answer all questions)

I write with my: ☐ Right hand ☐ Left hand

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do you live: ☐ Alone ☐ With others:_____

Are you: ☐ Employed: (Occupation) _____ ☐ Retired ☐ Disabled

Is your job duty: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy

Are you currently working: ☐ No ☐ Yes If no, for how long: _____

Do you smoke: ☐ No ☐ Yes If yes, how much: _____

Have you ever smoked: ☐ No ☐ Yes If yes, how many years: _____

Do you drink alcohol: ☐ No ☐ Yes If yes, how often per week: _____

Do you use illegal drugs: ☐ No ☐ Yes If yes, how often per week: _____

Highest level of education completed: ☐ High School ☐ College ☐ GED ☐ Other: _____

Physician Signature: _____

Orthopedic Surgery Specialists

PATIENT AGREEMENT FOR CONTROLLED SUBSTANCE

The treatment of pain is a necessary and important part of caring for the patients. We are committed to making sure we address your pain needs while providing you with alternatives designed to minimize the addictive potential of the treatments we use. In this regard, we have a Pain Management program in cooperation with Pain Management Consultants to insure you know about and have access to the best, safest treatments available. If your pain requires ongoing prescriptions for controlled substances with significant addiction potential we will be asking you to see a specialist. Controlled substances are often addictive and must be taken exactly as prescribed. To clarify our expectations in giving you this medication and to emphasize the risk of taking these substances we are asking you to read and sign agreement.

I, _____ , understand that if I am prescribed a controlled substance I must adhere to the following restrictions. **Failure to conform to any of the below listed restrictions may result in being dismissed as a patient and being reported to the police.**

1. I will not use alcohol/illegal drugs while being prescribed medication(s).
2. I will not take any other prescribed medication without first notifying my doctor.
3. I will notify my doctor immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty days (including Emergency Rooms and Immediate Care Centers). Legally, failure to do so is a Crime (Obtaining or Attempting to Obtain Drugs by Fraud and/or Deceit) and may be reported to the Police.
4. I will submit to random urine and/or serum drug screens as ordered.
5. I will purchase all of my medication at _____ pharmacy and authorize my doctor to communicate with the pharmacist.
6. I authorize my doctor communicate with all physicians that I have seen.
7. I understand that is illegal to share this medication.
8. I agree to keep my medication locked in order to prevent loss or theft.
9. I understand that I will be taken off this medication if there is evidence of addiction and/or abuse.
10. I understand that this medication may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and short-term memory impairment.
11. I agree to keep all scheduled appointments with my physician/therapist. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.
12. I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications.
13. I authorize this office to release a copy (or original) of this controlled substance agreement to the Police if I violate any of the listed terms of at their request.
14. (Y or N) Have you received ***any*** prescription medication from ***any*** other physician in the past thirty days? If yes, please list physician and medication on the back of this sheet.
15. I understand that I may be called at any time to the office for a count of all my remaining medications. I agree to arrive on the day notified and **will be responsible for any cost this may incur**.
16. I waive my right of privacy and authorize my doctor to contact any healthcare provider, legal authority, friend and/or relative in order to obtain or provide information about my care (including abuse of controlled substances).

No refills will be authorized on weekends, holidays, after office hours or by producing a police report. Lost/stolen medications will not be replaced.

Patient Signature:_____ Date: _____

Physician's Signature:_____ Date: _____