Orthopaedic & Spine Center – Patient Demographics

PATIENT INFORMATION

Name: ____ **Birth Date:** _______________ **Date:** ____________________
Patient Address: ____
City: _________________________________ Zip Code: ___________________
Home Phone: _____________________________ Cell Phone: _______________________ Work: __________________
May we leave a message on answering machine/voicemail? Yes________ or No _______
Sex: M________ F ________ DOB: _____________________ Age: _________ SSN#: ___________________________
Email Address: ____Preferred Language: __________________
Marital Status: Single________ Married __________ Divorced _________ Widowed_________
Race: American Indian/Alaska Native ______ Asian _____ Black/African American ________ White _______
Native Hawaiian/Other Pacific Islander ______ Decline to answer ________
Patient Employer: _______________________________________ Occupation: ________________________________
Employment Status: Full Time _____ Part Time ______ Self Employed ______ Not Employed ______ Retired _______
Emergency Contact: _________________________________ Relationship to Patient: ____________________________
Contact number: ____________________________________ Alternate Contact Number: ________________________

BWC
Is the reason for your visit today the result of a work injury? Yes ______ No _______
Claim #: __________________________ Date of Injury: _________________ Claim Settled? Yes _____ No ______
Do you have other active BWC Claims? Yes _____ No ______ Claim #: ___________________________________

Physician Information
Referring Physician: __________________________________ Phone: ____________________ Fax: ______________
Primary Care Physician: _______________________________ Phone: ____________________ Fax: ______________

Pharmacy Information: Name: ________________________________ Phone: _________________________________

INSURANCE INFORMATION
Primary Insurance: _____________________________________Name of Policy Holder: ________________________
Policy #: ____ Group Number: ____________________________________
Policy Holder DOB: ________________ Relationship to Policy Holder: _______________________________________
Secondary Insurance
Primary Insurance: _____________________________________ Name of Policy Holder: ________________________
Policy #: ____ Group Number: ____________________________________
Policy Holder DOB: ________________ Relationship to Policy Holder: _______________________________________

Reason for today's visit: ____
Date Condition Began**:** _______________________Was this the result of a work injury? Yes ____ No _______
If so, please describe: ____
Have you been treated previously for this condition? Yes _____ No ______
If yes, please describe treatment: ____

Rate your pain with medication
0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain

Rate your pain without medication
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

Please check the word that best describes your pain:
Constant _______ Intermittent______ Aching _______ Stabbing ______ Burning______ Shooting _______
Shock –like ______ Deep ______ Abnormal Skin Sensitivity _______

Do you have numbness and/or tingling in arms /legs? Yes ______ No ______
If yes, please explain: ____
____

What makes your pain better? ____
What makes your pain worse? ____

Please check all previous or current used methods of pain management:
Acupuncture _______ Chiropractic ________ Homeopathy ________ Medication ________ Exercise ________
Biofeedback _______ Injections __________ Surgery ________ Hypnosis ________ Herbal Medication ________
Massage _______ Other:____
Have you ever had physical therapy for this condition? Yes _____ No ______ If yes, when? _______________________
How many PT visits? 1-6 ______ 7-12 _______ more than 12 _________
Please check any of the following medications that you have tried to treat this condition:
Ibuprofen (Advil, Motrin) ________ Naproxen (Aleve, Naprosysn)________ Celebrex _________ Mobic _______

Imaging: Please list previous and most recent imaging studies completed prior to today for current complaint:

Date: ________ Test Performed ______________________ Body Part ____________ Facility _____________________
Date: ________ Test Performed ______________________ Body Part ____________ Facility _____________________

MEDICAL HISTORY

Past Medical History: Please check any medical conditions for which you have been treated in the past.

Anxiety ____________	Depression ___________	Heartburn __________	Osteoarthritis __________
Artificial Join ________	Diabetes ______________	High Blood Pressure ______	Poor Circulation _________
Asthma _____________	Epilepsy/ Seizures _______	Kidney Disease __________	Rheumatoid Arthritis ______
Bleeding Disorder _____	Fibromyalgia __________	Liver Disease ___________	RSD _______
Colitis _____________	Gout __________	Lung Disease ____________	Sleep Apnea ________
Defibrillator _________	Headaches _____________	MRSA __________	Thyroid Disorder _______
Stroke/TIA __________	Heart Disease __________	Obesity __________	Ulcer ________

Other: ____

Are you CURRENTLY experiencing any of these conditions/symptoms? (Please check all that apply)

Fever ________	Temperature Changes _______	Sudden Loss of Bladder Control _______
Chills ________	Discoloration _________	Sudden Loss of Bowel Control ________
Chest Pain _________	Weight Loss _________	Excessive Bleeding ________
Heart Murmur or Irregular Rate ________	Joint Swelling ________	Shortness of Breath __________
	Joint Pain ________	Difficulty Swallowing _________
Blood Clots __________	Weakness ________	Difficulty Sleeping __________
Unusual Bruising _______	Numbness/Tingling __________	Anxiety __________
Rashes ________	Migraines ___________	Other Mental Illness: _________________
Hair Loss __________	Depression __________	____________________________________

Medications: Please list all of the medications you are taking, including over the counter medications and herbal supplements. Please include dose and frequency.

1.____ 7.____
2.____ 8. ____
3.____ 9. ____
4.____ 10.____
5.____ 11.____
6.____ 12. ____

Do you take Fish Oil, Vitamin E, or Aspirin? Yes _______ or No ___________

Do you take blood thinners? (Coumadin/Warfarin, Heparin, Pletal, Effient, Aggrenox, Pradaxa, Aspirin 325mg, Brillinta, or Plavix Yes_______ or No _______ If yes, please list the blood thinner: ___________________________
Prescribing Physician: ____

Allergies: Please list all medications you are allergic to and what occurs when you take that medication.
If you have no known allergies, check this line: _______
1.____ 3.____
2. ____ 4.____

Do you smoke (currently or in the past)? Y__ N __If yes, how much? __________________ For how long? __________

Do you drink any alcoholic beverages? Y__ N__ If yes, how many days per week? ________ How many per day?______

Do you have or have you ever had a problem with substance abuse including prescription medication, street drugs, or alcohol? Yes ______ No ______ If Yes, please explain: ____

Past Surgical History: Please list below any operations with the date.

1.____ 4.____

2.____ 5.____

3.____ 6.____

Do you have a Pacemaker / Defibrillator? Yes _________ or No ________
If yes, name of company: ____
Name of Cardiologist managing the pacemaker / defibrillator: ____

Family History: For each of the following family members, please list their age (or age at death) and any illnesses including diabetes, high blood pressure, heart disease, cancer, kidney problem, lung problems, depression, allergies and arthritis.

Mother: ____

Father:____

Maternal Grandmother: ____

Maternal Grandfather:____

Paternal Grandmother: ____

Paternal Grandfather:____

Siblings: ____

Children: ____

PATIENT SIGNATURE: ____ **DATE**: ______________________