INSALL SCOTT KELLY

Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

PATIENT INFORMATION

Patient Name:		**Date:**
DOB:	**Height:**	**Weight**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? _____

II. Which side is affected? O Right O Left O Bilateral

III. Date of Injury or start of pain: _____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV: Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other: _____

Have you had physical therapy? O Yes O No

Are you taking any pain medications?

Anti-inflammatory agent O Yes O No Drug Name: _____

Pain Medication O Yes O No Drug Name: _____

Tylenol O Yes O No

Have you been putting ice on the area? O Yes O No

Have you had any testing? O Yes O No

Which tests? O X-Ray O MRI O EMG/NCS O Bone Scan O CT Scan

Medical History

Osteoporosis	O Yes	O No		Cancer	O Yes	O No	
Hypertension	O Yes	O No		Prolonged Steroid Treatment	O Yes	O No	
Diabetes	O Yes	O No		Degenerative Joint Disease	O Yes	O No	
Arthritis	O Yes	O No		Degenerative Disk Disease	O Yes	O No	

Social History

Do you smoke cigarettes? O Yes O No

How long have you smoked? O >1 year O 1-10 years O 10+ years

How many packs per day? O >1 pack O 1-2 packs O 3+ packs

Have you ever smoked cigarettes in the past? O Yes O No

Do you drink alcohol regularly? O Yes O No

How many drinks per day? O 1 drink O 2-3 drinks O 4+ drinks

Do you have a history of substance abuse? O Yes O No

Have you ever had a blood transfusion? O Yes O No

Do you participate in sports/recreational activities? O Yes O No

If yes, please list _____.

Family History

Mother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Father	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Paternal Grandmother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Paternal Grandfather	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Maternal Grandmother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Maternal Grandfather	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis

Review of Systems: *Are you experiencing any of these issues now?*

Constitutional

Fatigue	O	Yes	O	No
Weight change	O	Yes	O	No
Fever	O	Yes	O	No

Neurological

Migraine Headaches	O	Yes	O	No
Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No
Dizziness	O	Yes	O	No

Respiratory

Shortness of Breath	O	Yes	O	No
Trouble Breathing	O	Yes	O	No
Wheezing/ Asthma	O	Yes	O	No
Chronic Coughing	O	Yes	O	No

Cardiovascular

Chest Pain	O	Yes	O	No
Irregular Heartbeat	O	Yes	O	No
High Blood Pressure	O	Yes	O	No
Leg/Ankle swelling	O	Yes	O	No

Musculoskeletal

Joint pain	O	Yes	O	No
Joint stiffness	O	Yes	O	No
Joint swelling	O	Yes	O	No
Back Pain	O	Yes	O	No

Gastrointestinal

Nausea/ Vomiting	O	Yes	O	No
Stomach Ulcer	O	Yes	O	No
Diarrhea	O	Yes	O	No
Blood in stool	O	Yes	O	No

Skin

Rashes/sores	O	Yes	O	No
Skin Cancer	O	Yes	O	No
Itching/ Burning	O	Yes	O	No

Hematologic

Anemia	O	Yes	O	No
Easy Bruising	O	Yes	O	No
Bleeding problem	O	Yes	O	No

Other

Sexually Transmitted Diseases O Yes O N

Allergies

Are you allergic to any medications? O Yes O No If yes, please list:_____

Are you allergic to food or environmental substances? O Yes O No If yes, please list:_____

Medications (Please list name of medication and dosage)	
Hospitalization (Please list)	**Surgeries (Please list surgery type and year)**

Patient Signature _____ **Date** _____