

Southeastern Orthopaedic Specialists

Date: _____ Chart # _____ Provider _____

Patient Name (Please Print) _____

BP _____ / _____	Pulse _____
Temp. _____ H _____ / _____ W _____	

Patient Signature _____

Age _____ F M Height _____ / _____ Weight _____ Did you bring x-rays? Y N

Who requested that you visit this office? Doctor (Name) _____ Self-Referral Attorney _____

★ What is the main reason for this visit? Pain Numbness Weakness Other _____ (Chief Complaint)

★

What body part is involved?						(Location)
Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L

How long has this problem been present? _____ Days Weeks Months

Check the box which best fits how your problem started. Then answer the one question below the box you checked. Use as much space to the right as needed.

NO INJURY (Onset was: Gradual or Sudden) **ANSWER:**

?Why do you think it started?

INJURY – (NOT AUTO OR WORK)

Date _____, Where and How did it Happen?

INJURY AT WORK

Date _____, Where and How did it Happen?

WORK RELATED – (BUT NO INJURY)

Date _____, How did your job cause this problem?

AUTO ACCIDENT

Date _____, Where and How was your car hit?

Please check the box below which best describes your problem:

- ★ **The pain is** Constant Comes and goes (Intermittent) (Duration)
- ★ **Severity** of pain Mild Moderate Severe Extremely severe (Severity)
- ★ What is the **quality** of the pain? Sharp Dull Stabbing Throbbing Aching Burning Other: _____ (Quality)
- Are there **associated symptoms**? Swelling Numbness Weakness (Assoc Symp)
- Since my problem started, it is: Getting better Getting worse Unchanged (Context)
- Does your pain wake you from sleep? Yes No (Timing)
- What makes your symptoms **worse**? Activity Exercise Work Other _____ (Modify)
- Which make you feel **better**? Rest Heat Ice Elevation Other _____ (Modify)
- What medications have you taken or been prescribed for this problem? _____ (Modify)
- Check which treatments you have tried: Injection Y N Brace Y N Therapy Y N Cane/Crutch Y N (Modify)

REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following health problems?

N2E3
(MS)

1) M/S • Have you had a prior problem with this same Orthopaedic condition in the past? Y N (explain below)

• Have you had prior Back Pain Joint Swelling Prior Fracture Arthritis _____

N3E4
(2-9)

2) ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N If yes, please list _____

3) ARE YOU A DIABETIC? Y N TREATMENT: Insulin Oral Meds Diet None

N4,5
E5
(14)

(Please check any that apply, or mark None)

None Year

Explain Details/Comments

4) CON weight loss Loss of appetite Fever Cancer _____

5) EYE Glasses Contacts Double Vision Cataract _____

6) ENT Hearing Loss Hoarseness Ringing in Ears _____

7) CV High blood pressure Heart attack Blood clots _____

8) RS Asthma Cough Pneumonia Short of Breath TB _____

9) GI Stomach ulcer Hepatitis Blood in Stool _____

10) GU Pain with Urination Blood in Urine Kidney disease _____

11) SK Skin Ulcers Rash Lumps _____

12) NEU Seizures Stroke Balance Problem Headaches _____

13) PSY Depression Nervousness Sleep disorder _____

14) HEM Easy bleeding Easy bruising Anemia _____

PAST MEDICAL HISTORY

N3/E4
(1)

★ WHAT MEDICATIONS DO YOU TAKE? None Please list with dosage: _____

N4,5
E5
(1)

ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BLOOD THINNERS? Y N If yes, (type) _____

PAST HOSPITALIZATIONS (Not for surgery) None _____

PAST SURGICAL HISTORY: What operations have you had? When? None _____

Have you ever had a reaction to anesthesia? Y N

N4,5
E5
(1)

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

★ Any direct relative with the same Orthopaedic condition you are being seen for today? Y N _____

Diabetes Y N _____ High Blood Pressure Y N _____ Heart disease Y N _____ Arthritis Y N _____

N4,5
E5
(1)

SOCIAL HISTORY:

★ Do you use tobacco? Y N Packs per day _____ Alcohol use? Y N How often? Daily Other ____/ week

Marital History: M S D W How many people live with you? _____

Occupation: _____ Student Employer: _____

Are you currently working? Y N If no, how long have you been off work? _____

For Office use only

Reviewed for completeness by _____ Date ____/____/____ Reviewed by MD _____ Date ____/____/____

Reviewed by MD _____ Date ____/____/____ Reviewed by MD _____ Date ____/____/____

Welcome To Our Office

New Patient Information

Date _____

PATIENT'S NAME (PLEASE PRINT) (FULL NAME)	S.S.#	BIRTHDAY	AGE	SEX		MARITAL STATUS				
				M	F	S	M	W	D	SEP
STREET ADDRESS		CITY AND STATE				ZIP				
HOME PHONE		CELL PHONE								
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)				BUS. PHONE		EXT.		
EMPLOYER'S STREET ADDRESS		CITY AND STATE				ZIP				
CONTACT PERSON'S NAME IN CASE OF EMERGENCY		PHONE								
SPOUSE OR PARENT'S NAME		S.S.#			BIRTHDATE					
SPOUSE OR PARENT'S EMPLOYER'S		EMPLOYER'S STREET ADDRESS				BUS. PHONE		EXT.		
SPOUSE'S STREET ADDRESS		CITY AND STATE				ZIP				
NAME AND ADDRESS OF REFERRING PHYSICIAN		NAME AND ADDRESS OF PRIMARY CARE PHYSICIAN (FAMILY DR.)								
PLEASE COMPLETE THIS SECTION (EVEN IF WORKMAN'S COMP.) AND PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST.										
PERSON RESPONSIBLE FOR PAYMENT		STREET ADDRESS, CITY, STATE			ZIP		HOME PHONE			
PRIMARY INSURANCE CO. NAME		CERTIFICATE #				GROUP #				
POLICYHOLDER'S NAME		POLICYHOLDER'S BIRTHDATE								
SECONDARY INSURANCE CO. NAME		CERTIFICATE #				GROUP #				
SECONDARY INS. POLICYHOLDER'S NAME		SECONDARY INS. POLICYHOLDER'S BIRTHDATE								
WHAT ARE YOU SEEING THE DOCTOR FOR TODAY?		DATE OF ONSET		DESCRIPTION OF PROBLEM OR INJURY						
IF THIS IS A WORK RELATED INJURY (PLEASE FILL OUT THIS SECTION)				BRIEF DESCRIPTION OF HOW ACCIDENT HAPPENED						
NAME OF EMPLOYMENT WHERE INJURY HAPPENED?				COMPLETE ADDRESS OF THAT EMPLOYER						
WAS AN AUTOMOBILE INVOLVED?			DATE OF ACCIDENT		NAME OF ATTORNEY					
<input type="checkbox"/> YES <input type="checkbox"/> NO STATE _____										

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES AND COPAYMENTS REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE PERSONNEL.

VERY IMPORTANT:
PLEASE BRING INSURANCE CARDS, XRAY'S, MRI'S AND ANY OFFICE NOTES RELATING TO TODAY'S VISIT.

Guilford Orthopaedic and Sports Medicine Center
A Division of Southeastern Orthopaedic Specialists
1915 Lendew St.
Greensboro NC, 27408

Patients Name: _____

Patients Ins: _____

Date of First Service: _____

During the past three years, have you had treatment by an Orthopaedic Surgeon in Greensboro?

Yes _____

No _____

If yes, please indicate the name of the physician and/or practice below:

Name of Doctor and/or Practice

Date of Service

Patient Signature

Date