



PATIENT INFORMATION

Which doctor are you here to see? (Please circle one)

- Stephen M. Wilson, M.D.
- Joe A. Morgan, M.D.
- Lawrence J. Messina, M.D.
- William F. Hagemann, M.D.
- Gerard L. Murtagh, M.D.
- David M. Pope, M.D.
- Joseph E. Broyles, M.D.
- Kevin P. McCarthy, M.D.
- Alan C. Schroeder, M.D.
- Charles S. Walker, M.D.

Account# _____
FOR OFFICE USE ONLY

- Kevin B. Riché, M.D.
- Christopher J. Belleau, M.D.
- Patrick B. Hall, D.P.M.
- O. Christian Hall, D.P.M., FACS

Have you been a patient here before? Yes No

Patient Name:

First _____ MI _____ Last _____

Mailing Address:

Street _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ Cell/Alternate Phone _____

Age: _____ Date of Birth: _____ Social Security #: _____ Gender: F M

Email: _____ Would you like our FREE *Doctor's Orders e-newsletter*? Y N

Marital Status: (Circle one) Married Single Divorced Widowed Spouse's Name: _____

Employer: _____

Primary Care Physician: _____

Student: Parent(s) or Legal Guardian(s) Name: _____

Address (if different from primary): _____

Street _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ Cell/Alternate Phone _____

Emergency Contact Name: _____

Need different address Relationship to Patient _____ Home Phone _____ Cell/Alternate Phone _____

Medical Insurance Information:

- 1. Will you be filing today's visit through your personal health insurance? **If so, present card to front desk.**
- 2. Is this a job related injury? **If so, complete section II.**
- 3. Is your visit today part of a legal, disability or liability related issue? **If so, complete section III.**

I. REFERRED BY:

Name: _____ Primary Dr.? YES NO

Other: Please explain: _____

II. Workmen's Compensation Claims: (Please complete if your visit is the result of a work related injury.)

DATE OF INJURY/ACCIDENT: _____ DID YOU REPORT THIS TO YOUR EMPLOYER? YES NO

Employer _____ Work Compensation Contact Person _____ Contact's Phone _____

Employer Address _____ City _____ State _____ Zip Code _____

Work Compensation Carrier _____ Phone _____ Claim Number _____ Adjuster _____

III. Legal/Disability/Liability Claims: (Please complete if your visit is the result of legal, disability or liability issue.)

DATE OF INJURY/ACCIDENT: _____

Law Office/Disability/Liability Office Name _____ Lawyer's/Agent's Name _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

I Hereby Authorize The Bone and Joint Clinic to release any medical information and/or medical records maintained at this clinic as needed to my insurance company, to the social security administration or carriers, to my attorney as listed above, or to the attorney responsible for the payment for medical services or evaluation to be provided. I permit a copy of this authorization to be used in place of the original. I hereby assign to the facility listed above all Insurance Company or Medicare reimbursements for medical and/or surgical expenses. Regulations pertaining to Medicare assignment of benefits apply.

Date

Signature (Patient or Responsible Party)

Name of Person Completing Form

Relationship to Patient

MEDICAL HISTORY FORM

PATIENT NAME: _____
First MI Last

Age: _____ Height: _____ Weight: _____ Date of Birth: _____

Gender: Female Male I am: Left Hand Dominant Right Hand Dominant

Primary Care Physician: _____

WHO RECOMMENDED YOU TO SEE US:

Name: _____ Primary Dr.? Yes No

Other: Please explain: _____

CHIEF COMPLAINT: Why are you here? _____

Date of Injury or Onset of Symptoms: _____ **Body Part to be Examined:** _____ **Left Right**

(Circle all that apply)

Main Problem: pain numbness weakness stiffness
unstable swelling popping/grinding other: _____

Where complaint/injury occurred: work at home sports/recreational
car accident at school other: _____

How complaint/injury occurred: gradual onset sudden/traumatic
unknown other: _____

Severity of Pain: mild moderate severe extremely severe

Quality of Pain: sharp dull stabbing throbbing aching burning

PREVIOUS AND/OR CURRENT TREATMENTS FOR THIS CONDITION: *(Circle all that apply)* None

X-rays/Tests: Regular x-rays MRI scan CAT scan Myelogram Nerve tests (EMG, NCV)
Other: _____ Did you bring your X-rays with you? _____

Medications: Anti-inflammatories Muscle relaxants Pain medication Other: _____

Therapies: Physical therapy Chiropractic care Injections Other: _____

ARE YOU PREGNANT? YES NO

GENERAL MEDICAL HISTORY:

Are you affected by any of the following? *(Circle all that apply)* **No medical problems**

Abnormal heart rhythm Bleeding disorders Diabetes Heart failure HIV Osteoporosis Stroke
Acid Reflux Blood clots Gout Hepatitis Kidney problems Rheumatoid arthritis Cancer
Asthma Depression Heart attack High blood pressure Lung Problems Stomach ulcers

If you circled any of the above, please explain: _____

SOCIAL HISTORY: *(Circle all that apply)*

A. Occupation: _____

B. Are you on: Full Duty Light Duty (since: _____) Disabled (since: _____)

C. Do you use tobacco products? no less than 1 pack 1 pack more than 1 pack

D. Do you use alcohol? no occasionally daily

E. What is your living status? alone with spouse with parents with roommate assisted living/nursing home

PREVIOUS SURGERIES: None

Please list the type and date the surgery was performed.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Have you ever had a problem with a general anesthetic? (*Circle one*) Yes, explain below No

If yes, describe any problems: _____

CURRENT MEDICATION: None

Pharmacy Preference and Phone #: _____

Please list any prescriptions, drugs, and/or non-prescription medications, including vitamins, nutritional supplements, or anything taken orally.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

ALLERGIES: Do you have any known drug allergies? If yes, explain below None

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

FAMILY HISTORY: Please indicate if anyone in your family has had the following: (*Circle all that apply*)

Cancer (Type): _____ Rheumatoid Arthritis Diabetes Scoliosis Heart Disease
 Other: _____

REVIEW OF SYSTEMS:

Are you experiencing any of the following? (*Circle all that apply*) **None apply**

- | | | | |
|------------------------|-------------------------|---------------------|--|
| Blackouts/fainting | Difficulty with balance | Heartburn | Stomach pain or ulcers |
| Burning with urination | Fevers, chills, sweats | Nausea or vomiting | Stress |
| Cough | Frequent rashes | Seizures | Unexplained weight loss |
| Depression | Heart or chest pain | Shortness of breath | Urinary incontinence, frequency, urgency |

Signature of patient, parent, or guardian Date

Physician's signature Date

REVIEWED BY MD	DATE	INIT	DATE	INIT	DATE	INIT	DATE
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NAME OF PERSON COMPLETING THIS FORM

PATIENT NAME: _____

First

MI

Last

PAIN DIAGRAM

On a scale of 1- to -10, how would describe your pain level when it is at its worse?

No Complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Pain
	0	1	2	3	4	5	6	7	8	9	10

Place an "X" on the area of pain; use the appropriate symbol of other symptoms you feel. If you are being seen for your foot or hand/wrist, use the diagrams at the bottom.

Pain
xxx

Aching
ccc

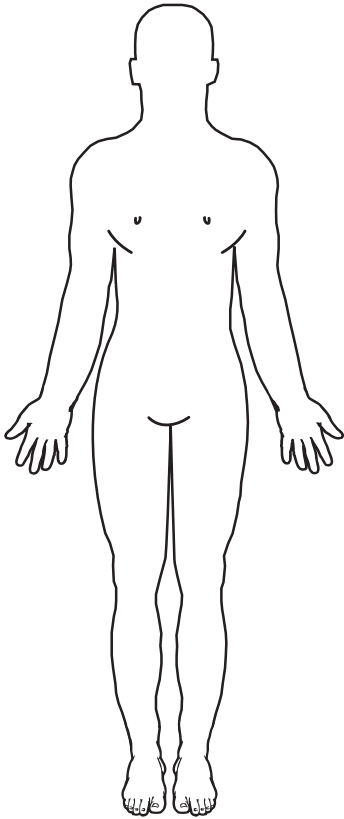
Numbness
+++

Pins & Needles
...

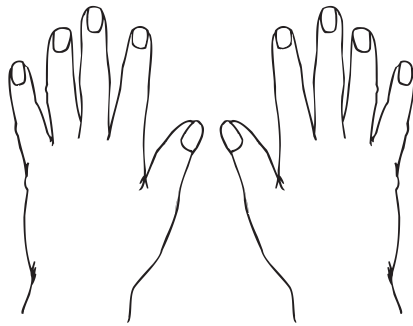
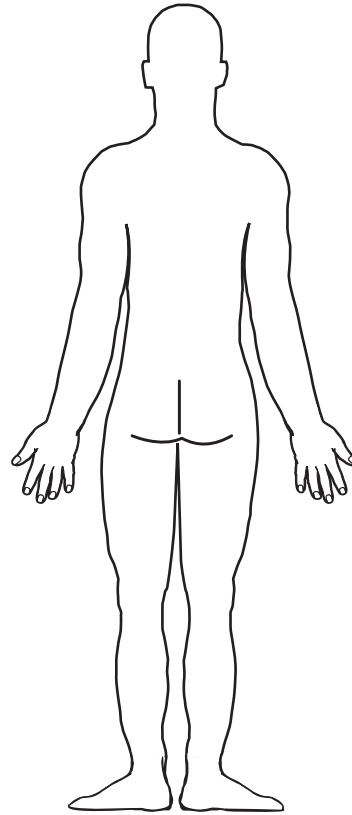
Burning
√√√

Stabbing
///

Front View

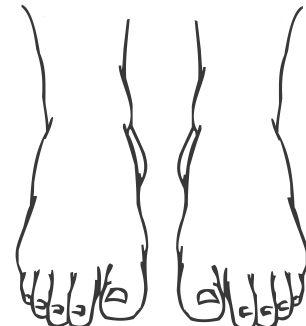


Back View



Left

Right



Right

Left

Signature

Date

Name of Person Completing this Form