# SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

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## PATIENT INFORMATION (ESTABLISHED NEW PROBLEM)

**PATIENT'S NAME**_____ **DATE** _____

**HAVE YOU EVER BEEN TREATED BY THESE DOCTORS?** ☐ **Yes** ☐ **No** **If so, what doctor?** _____

**CELL PHONE** _____ **HOME PHONE** _____

**ADDRESS**_____

**CITY**_____ **STATE**_____ **ZIP**_____

**MARITAL STATUS:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widow** **AGE**_____

**PRIMARY DOCTOR: Dr.**_____ **Address**_____

**PHARMACY NAME**_____ **LOCATION**_____ **PHONE**_____

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***NOTATE ANY CHANGES TO EMPLOYMENT AND/OR HEALTH INSURANCE SINCE YOUR LAST VISIT:***

**EMPLOYER'S NAME & ADDRESS** _____

**EMPLOYER'S PHONE #**_____ **OCCUPATION**_____

**NAME OF SPOUSE/ PARENT**_____

**SPOUSE/PARENT ADDRESS**_____

**SPOUSE/PARENT SOCIAL SECURITY #/** _____

**SPOUSE/PARENT EMPLOYER'S NAME** _____

**SPOUSE/PARENT EMPLOYER'S PHONE** _____

**PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT** _____

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**PRIMARY INSURANCE COMPANY NAME** _____

**PRIMARY INSURANCE COMPANY ADDRESS** _____

**GROUP #** _____ **POLICY #**_____ **SUBSCRIBER NAME** _____

**SUBSCRIBER DATE OF BIRTH** _____ **SUBSCRIBER SOCIAL SECURITY #**_____

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**SECONDARY INSURANCE COMPANY NAME** _____

**SECONDARY INSURANCE COMPANY ADDRESS** _____

**GROUP #** _____ **POLICY #**_____ **SUBSCRIBER NAME** _____

**SUBSCRIBER DATE OF BIRTH**_____ **SUBSCRIBER SOCIAL SECURITY #**_____

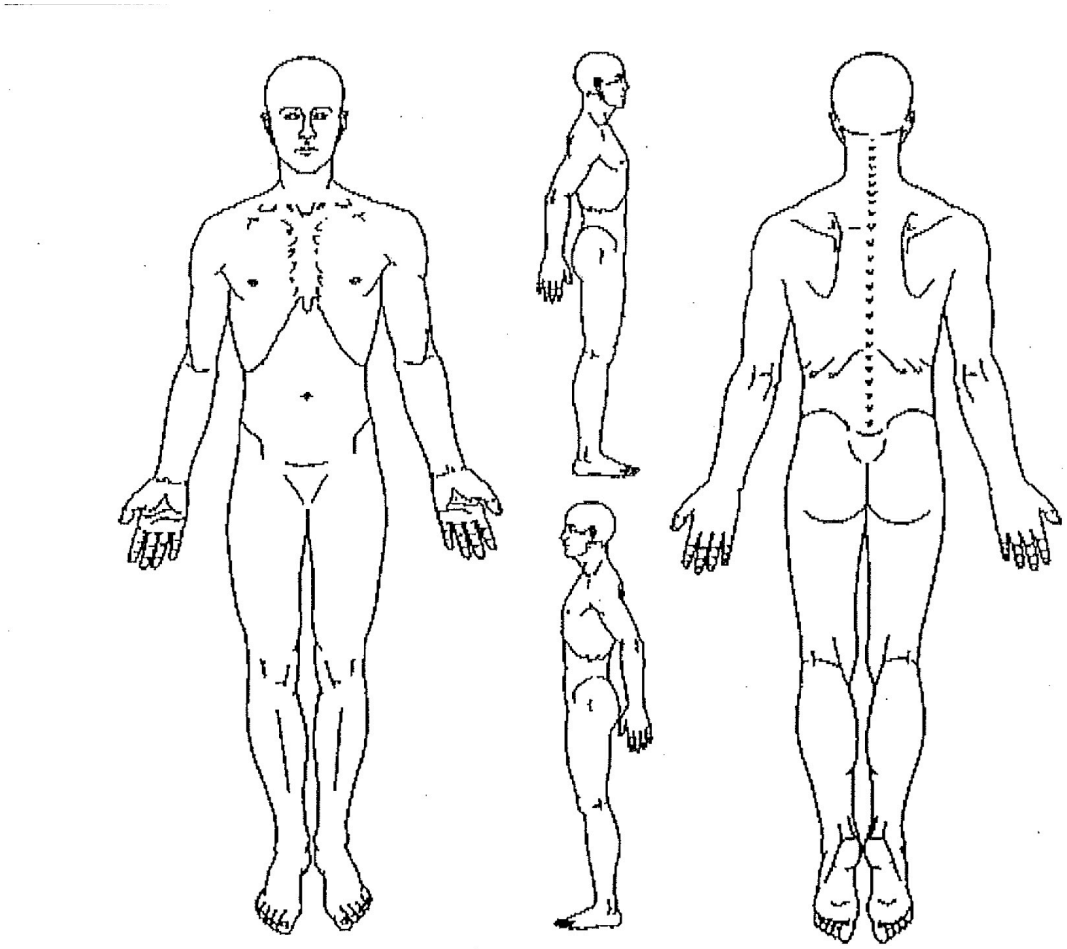
## SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

## COMPLAINT DIAGRAM (ESTABLISHED NEW PROBLEM)

**PATIENT'S NAME:**_____ _____ **DATE:**_____

**How long have you had pain** _____**Weeks** _____**Months** _____**Years**

***On the diagram below, please indicate where you are currently experiencing pain or other symptoms.***



| | | |
|---|---|---|
| **A = ACHE** | **B = BURNING** | **N = NUMBNESS** |
| **P = PINS & NEEDLES** | **S = STABBING** | **E = ELECTRICAL** |

# SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

## MEDICAL HISTORY & INTAKE FORM (ESTABLISHED NEW PROBLEM)

**Patient's Name**:_____ **Date**: _____

**PATIENT HISTORY:**

**Reason for visit:** _____**Patient Age:** _____

**For how long has this been bothering you?** _____

**If Upper Extremity Involved, What is Your Dominant Hand** **Right** ☐ **Left** ☐

**Pain at Rest or Pain That Awakens From Sleep?** _____

**Severity (Mild/Moderate/Severe)**_____

**What Makes Symptoms Better?** _____

**What Makes Symptoms Worse?** _____

**Describe Any Prior Treatment (Surgery/Therapy/Injections/Medications)**

_____

_____

_____

_____

**ANY NEW MEDICAL PROBLEMS OR SURGERIES SINCE YOUR LAST VISIT:**

_____

_____

_____

**SOCIAL HISTORY - ANY CHANGES IN THE FOLLOWING SINCE YOUR LAST VISIT:**

Employment_____

Living Situation_____Alcohol Use (amount & type)_____

Drug Use (amount & type)_____Tobacco Use (# of packs/cigarettes daily)_____

**ANY NEW ALLERGIES:**

_____

_____

**ANY NEW MEDICATIONS SINCE YOUR LAST VISIT (INCLUDING VITAMINS AND SUPPLEMENTS):**

_____

_____

**REVIEW OF SYSTEMS - Are you currently having or have you had problems with:**

***CIRCLE ALL THAT APPLY***

| NO | YES | |
|---|---|---|
| ☐ | ☐ | Arthritis Swelling of Joints Osteoporosis Fibromyalgia Fractures Muscle Atrophy |
| ☐ | ☐ | Rashes Masses or Lumps Problems with Scars Itching |
| ☐ | ☐ | Headaches Stroke Seizures Weakness |
| ☐ | ☐ | Depression Sleep Disorders Hallucinations Anxiety Disorder |
| ☐ | ☐ | Diabetes Thyroid |
| ☐ | ☐ | Easy Bruising or Bleeding Anemia Swollen Glands or Lymph Nodes |
| ☐ | ☐ | Dermatitis Latex Allergy Food Allergy Environmental Allergy |
| ☐ | ☐ | Asthma Wheezing Cough COPD Coughing up Blood |
| ☐ | ☐ | Nausea Vomiting Stomach Pain Bloody Stools Diarrhea Constipation Loss of Appetite |
| ☐ | ☐ | Difficulty with Urination Pain or Burning on Urination Blood in Urine Incontinence Menstrual Problems Prostate Problems Erectile Dysfunction |
| ☐ | ☐ | Fever Night Sweats Chills Weight Loss Tiredness Malaise |
| ☐ | ☐ | Visual Problems Glasses |
| ☐ | ☐ | Hearing Problems Sinus Problems Vertigo Dizziness Hoarseness |
| ☐ | ☐ | Ankle Swelling High Blood Pressure |
| ☐ | ☐ | Chest Pain Shortness of Breath Abnormal Heart Beat |

For all questions answered YES, explain: _____

_____

_____

_____

***IF VISIT TODAY IS FOR PAIN OR INJURIES SUSTAINED IN AN ACCIDENT (AUTOMOBILE, WORK PLACE, OI OTHER), ANSWER THE FOLLOWING QUESTIONS. OTHERWISE SKIP TO LAST PAGE AND SIGN)**

1. Nature of illness/injury/accident:
   Auto_____
   Work _____
   Other _____
2. Name and address of attorneys involved in this case, if applicable:

   _____

   _____

   _____
3. Accident Date_____
4. Accident Location_____
5. Accident Time_____
   Please describe the circumstances _____

   _____

   _____

****IF AUTO ACCIDENT, ANSWER QUESTIONS 6-19. OTHERWISE SKIP TO QUESTION 20**

**6.** What kind of car were you in?_____

**7.** Where were you seated?
_____Front Driver _____Front Passenger _____Rear Driver side _____Rear Passenger side

**8.** Were you going?
_____North _____South _____East _____West

**9.** Were you moving or stopped? _____Moving ____Stopped

**10.** What was the approximate speed of your vehicle? _____mph

**11.** Where on your vehicle were you hit:
_____In the front head on _____In the front left side _____In the front right side
_____In the rear _____In the rear left side _____In the rear right side OR Other (list)_____

**12.** At the time of impact I was looking:
_____Straight ahead _____ To the left _____ To the right

**13.** Were you wearing your seatbelt? _____Yes _____ No

**14.** Were there airbags in your vehicle: _____Yes _____No
If so, did they deploy? _____Yes _____ No

**15.** I was thrown after impact:
_____Forward _____Backward _____Side-to-side

**16.** I struck:
_____Dashboard _____ Headrest _____Windshield _____Rear view mirror _____Door _____Seat belt
_____Side window _____Steering wheel _____Other (list)_____

**17.** What part of your body did you strike?
_____Head _____Chest _____Face _____Knees _____Arms _____Shoulder
_____Other (list)_____

**18.** I had:
_____Cuts _____Bruises _____ OR _____Both
on my: _____

**19.** _____I was _____ I was NOT unconscious at the scene of the accident.

**20.** Was there:
_____Momentary Deafness _____Loss of Balance _____Nausea _____Ringing in Ears
_____Blurred visión _____Immediate Pain _____Dizziness

**21.** I was taken from the scene of the accident by:
_____Ambulance _____Friend _____Parents _____Mother _____Other (list)_____
_____To Hospital _____Home _____ Other (list)_____

**22.** When did you first seek medical attention for this accident?_____

Who did you see? _____

**23.** At (hospital name)_____

I was examined by _____

**24.** Were you admitted? _____Yes _____No

**25.** I was examined and given:

_____X-Rays _____Medication _____Neck Collar _____Brace ____Stitches

_____Other (list)_____

**26.** After your release, what did you do?

_____Return Home to Bed _____Return to Work

_____Other (list)_____

**27.** Work:

Have you lost any time from work since the accident?: _____Yes _____No

1. Are you still off work? _____Yes _____No

2. If not, date returned to work _____

**28.** Give names of all other doctors that treated you for injuries from your accident:

A. Name_____ Date_____

What did he/she do?_____

What did he/she say was wrong? _____

_____

B. Name_____ Date_____

What did he/she do?_____

What did he/she say was wrong? _____

_____

**29.** Check symptoms you have noticed since the accident:

A_____ Mid back (pain, stiffness)

B_____ Low back (pain; stiffness)/

C_____ Swelling?

Where?_____

D_____ Restriction of neck motion

E _____ Upper back pain and stiffness/

F _____ Pins & needles in:

_____Arms _____Legs

G_____ Numbness in:

_____Fingers _____Arms _____Legs

H_____ Headache

I _____ Neck pain

K_____ Difficulty in excessive

_____Standing _____Walking

_____Riding _____Bending

L _____ Neck pain, stiffness upon arising

M _____Low back pain, stiffness on arising

N _____ Pain radiating into:

_____Arm _____Leg

O_____ Difficulty in lifting:

_____Light _____Moderate

_____After lifting a few times

P _____ Pain radiating into:

_____Neck

_____ Base of skull

_____ Arms

_____ Hips

_____ Legs

**30.** I have pain in the following areas (most severe first, list all of them):

A. _____

B. _____

C. _____

D. _____

E. _____

**31.** My symptoms are aggravated by:

_____Walking _____Standing ____Lifting _____Turning _____Working

_____Sitting _____Playing sports _____ Lying down ___Exercise

_____Other (list) _____

**32.** My symptoms are helped by:

_____Resting _____Medication _____Bed rest _____Ice packs _____Hot shower _____Aspirin

_____Other (list) _____

**33.** Medication presently taking related to the injury (list all):

A. _____ D._____

B._____ E._____

C. _____ F._____

**34.** Have you had prior injuries or received treatment to the areas that are currently injured? If yes:

Date_____ Name of doctor_____

Address of Doctor_____

**35.** _____ I have or _____ I have NOT been able to work since the accident. If you have not, list dates unable to work:

From _____ To _____ Other_____

**36.** What activities have changed since the accident?

A. Employment: _____ No change _____ Cannot do work _____ Hurts to work

B. Exercise: _____ Can still exercise _____ Cannot exercise _____ Hurts to exercise

C. Housework: _____ Can still do housework _____ Can do limited housework

_____ Hurts to do housework _____ Cannot do housework

D. Sports: _____Can still do sports _____ Can do limited sports

_____Hurts to do sports _____ Cannot do sports

E. Lifting: _____Can still lift _____Can do limited lifting _____Hurts to lift _____Cannot lift

F. Other: _____

**37.** _____I have OR _____I have NOT been involved in other auto accidents.

If so, give date(s) and describe_____

**38.** _____I have _____ OR _____I have NOT been involved in ANY type of prior accident.

If so, give date(s) and describe _____

**39.** Do you have any type of disability or have you ever been given an impairment rating?

_____Yes _____No. If yes, explain_____

_____

_____

_____ _____

PATIENT'S SIGNATURE DATE

**FOR OFFICE USE ONLY:**

Liens and Cover letter sent out _____

Lien returned _____

Report fee paid _____

REV 8/26/2019