SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

THEODORE A. EVANS, M.D.
RICHARD F. PELL IV, M.D.
MICHAEL R. GOMBOSH, M.D.
Diplomates, American Board of Orthopaedic Surgery
JOHN F. TORREGROSA, D.P.M.
Fellow American College of Foot & Ankle Surgeons

Redwood Medical Pavilion
9165 S.W. 87th Avenue
Miami, Florida 33176-2302
Phone: 305.233.0011, Fax: 305.233.0033

Website: www.sfiortho.com

Portofino Professional Center
925 N.E. 30th Terrace, Suite 102
Homestead, Florida 33033-7914
Phone: 305.247.1701, Fax: 305.247.1799

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 #**_____

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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 CoughCOPD 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 TODAY IS FOR PAIN OR INJURIES SUSTAINED IN AN ACCIDENT (AUTOMOBILE, WORK PLACE, OR OTHER), ANSWER THE FOLLOWING QUESTIONS. OTHERWISE SKIP TO PAGE 7 AND SIGN)**

1. Nature of illness/injury/accident:
   Auto_____
   Work_____
   Other _____
2. Accident Date_____
3. Accident Location_____
4. Accident Time_____
   Please describe the circumstances _____

   _____

   _____

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

5. What kind of car were you in?_____

6. Where were you seated?
_____Front Driver _____Front Passenger _____Rear Driver side _____Rear Passenger side

7. Were you going?
_____North _____South _____East _____West

8. Were you moving or stopped? _____Moving ____Stopped

9. What was the approximate speed of your vehicle? _____mph

10. 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)_____

11. At the time of impact I was looking:
_____Straight ahead _____To the left _____To the right

12. Were you wearing your seatbelt? _____Yes _____No

13. Were there airbags in your vehicle:__Yes _No
If so, did they deploy?_____Yes _____No

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

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

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

17. I had:
_____Cuts _____Bruises _____ OR _____Both

on my: _____

18. _____I was _____I was NOT unconscious at the scene of the accident.

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

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

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

Who did you see? _____

22. At (hospital name)_____

I was examined by _____

23. Were you admitted? _____Yes _____No

24. I was examined and given:

_____X-Rays _____Medication _____Neck Collar _____Brace ____Stitches

_____Other (list)_____

25. After your release, what did you do?

_____Return Home to Bed _____Return to Work

_____Other (list)_____

26. 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 _____

27. 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? _____

_____

28. 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

29. I have pain in the following areas (most severe first, list all of them):
A. _____
B. _____
C. _____
D. _____
E. _____

30. My symptoms are aggravated by:
_____Walking _____Standing ____Lifting _____Turning _____Working
_____Sitting _____Playing sports _____Lying down ___Exercise
_____Other (list) _____

31. My symptoms are helped by:
_____Resting _____Medication _____Bed rest _____Ice packs _____Hot shower _____Aspirin
_____Other (list) _____

32. Medication presently taking related to the injury (list all):
A. _____ D._____
B._____ E._____
C. _____ F._____

33. Have you had prior injuries or received treatment to the areas that are currently injured? If yes:
Date_____Name of doctor_____
Address of Doctor_____

34. _____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_____

35. 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: _____

36. _____I have OR_____I have NOT been involved in other auto accidents.
If so, give date(s) and describe_____

37. _____I have_____OR_____I have NOT been involved in ANY type of prior accident.

If so, give date(s) and describe _____

38. 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 _____ __-__-__-__-__-__-__-__-____ __

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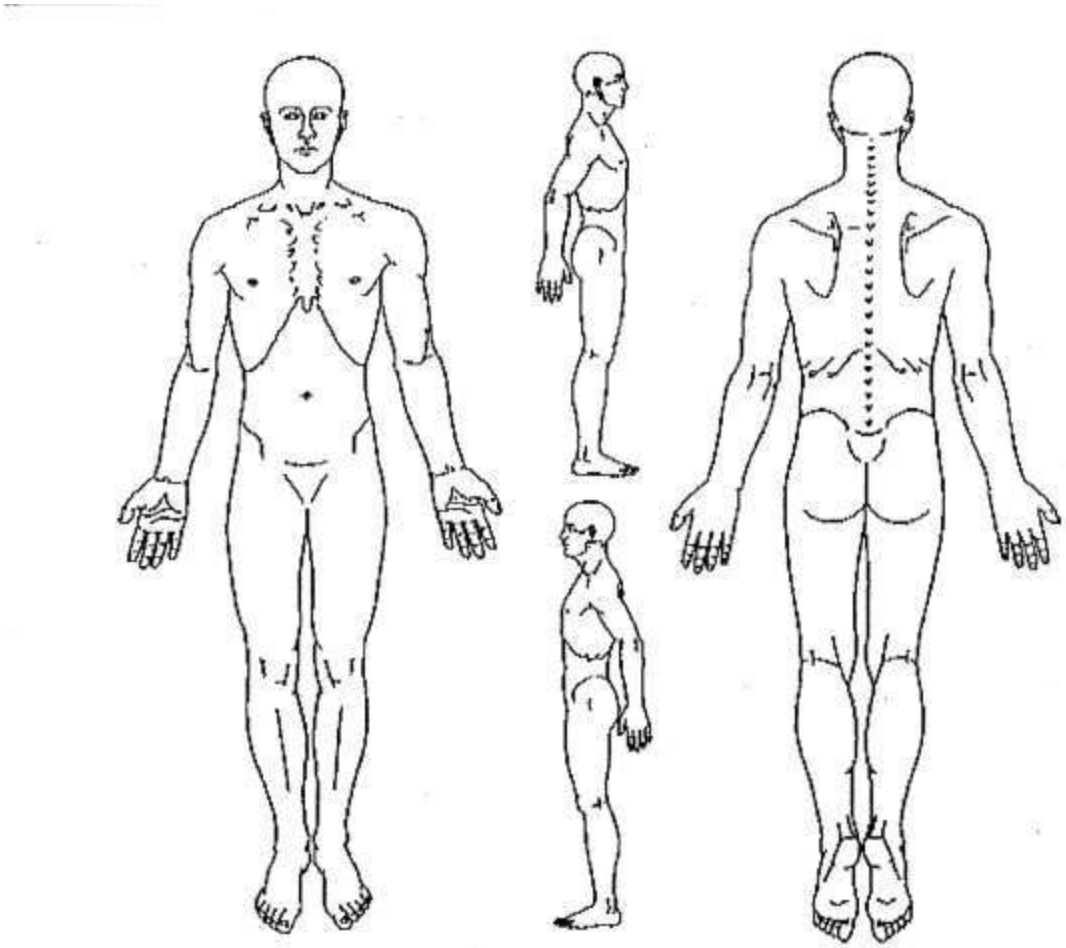
COMPLAINT DIAGRAM (ESTABLISHED NEW PROBLEM)

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**