Al Mollabashy, MD
Nathan F. Gilbert, MD
Cyrus Abbaschian, MD

Ashley Kalvaitis, PA-C
Jeffery Neumann, PA-C
Matthew Tassinari, PA-C
Jessica J. Wingfield, MD

Patient Name:_____ Social Sec Number: _____-_____-_____

Date of Birth: ____ / ____ / ____ Age: ____ Sex: M / F (circle one) Married Single Divorced Widow

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____

Employer Name: _____ Employer Phone#: (_____)_____

Employer Address: _____ City: _____ State: ____ Zip: _____

Referring Physician: _____ Phone#: (_____)_____

Primary Care Physician: _____ Phone#: (_____)_____

Pharmacy: _____ Phone#: (_____)_____

Person responsible for bill or parent *(Complete only if different from patient)*

THE ADULT ACCOMPANYING A MINOR TO HIS/HER APPOINTMENT IS RESPONSIBLE FOR PAYMENT

Guarantor Name: _____ Social Sec Number: _____-_____-_____

Relationship to Patient: _____ Date of Birth: ____ / ____ / ____

Address: _____ Phone#: (_____)_____

Employer Name: _____ Employer Phone#: (_____)_____

Employer Address: _____ City: _____ State: ____ Zip: _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ ID#: _____ Group#: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Employer: _____ Employer Address: _____

Policy Holder's Social Sec:_____-_____-_____ Policy Holder's Date of Birth: ____ / ____ / ____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ ID#: _____ Group#: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Employer: _____ Employer Address: _____

Policy Holder's Social Sec:_____-_____-_____ Policy Holder's Date of Birth: ____ / ____ / ____

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PATIENT HISTORY SURVEY

Patient Name: _____ ❑ M ❑ F Date of Birth: _____/_____/_____

Did you bring X-rays? ❑ Y ❑ N Labs? ❑ Y ❑ N Height: _____ Weight: _____

WHY ARE YOU HERE? (**CHIEF COMPLAINT**): _____

_____

HISTORY OF PRESENT ILLNESS:

WHAT BODY PART IS INVOLVED: ❑ R ❑ L ❑ Shoulder ❑ Arm ❑ Elbow ❑ Forearm ❑ Wrist/Hand ❑ Hip ❑ Thigh ❑ Knee ❑ Leg ❑ Ankle ❑ Foot ❑ Neck ❑ Back

How long have you had this problem: _____ ❑ Days ❑ Weeks ❑ Months ❑ Years

Did you have an injury? When? How? _____

_____

_____

ONSET: ❑ Gradual ❑ Sudden PAIN: ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

PAIN QUALITY: ❑ Sharp ❑ Dull ❑ Stabbing ❑ Throbbing ❑ Aching ❑ Burning

ASSOCIATED SYMPTOMS: ❑ Swelling ❑ Numbness ❑ Weakness ❑ Other _____

SINCE PROBLEM STARTED: ❑ Getting Better ❑ Getting Worse ❑ Unchanged

DOES PAIN WAKE YOU FROM SLEEP: ❑ Yes ❑ No

WHAT MAKES YOUR SYMPTOMS WORSE: ❑ Activity ❑ Exercise ❑ Work

WHAT MAKES YOU FEEL BETTER: ❑ Rest ❑ Heat ❑ Ice ❑ Elevation ❑ Other _____

DO YOU HAVE THE FOLLOWING: ❑ Fever ❑ Chills ❑ Sweats ❑ Weight loss

DO YOU HAVE DIFFICULTY WITH CONTROL: ❑ Bowel ❑ Bladder

TREATMENTS TRIED: ❑ Injection ❑ Brace ❑ Therapy ❑ Cane/Walker ❑ Chiropractor ❑ Other _____

PREVIOUS ORTHOPAEDIC HISTORY

PREVIOUS INJURIES: _____

_____

❑ Previous Joint Replacement ❑ Previous Fracture Surgery ❑ Previous Bone/Joint Infection

PREVIOUS TEST: ❑ X-Ray ❑ Bone Scan ❑ CT Scan ❑ MRI ❑ EMG/Nerve ❑ Other _____

Physician's Notes

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PAST MEDICAL HISTORY

❑ Bleeding Problems ❑ HIV ❑ Emphysema ❑ Stroke ❑ Migraines ❑ Asthma ❑ Hepatitis ❑ Polio

❑ Anemia ❑ Fibromyalgia ❑ Osteoporosis ❑ Stomach Problems (Reflux, Ulcers) ❑ Arthritis ❑ Heart Problems

❑ Neuropathy ❑ Thyroid Problems ❑ Diabetes ❑ Kidney Problems ❑ Pneumonia ❑ Blood Clots

❑ Pulmonary Embolism ❑ Epilepsy ❑ High Blood Pressure ❑ Psychiatric ❑ Depression/Anxiety

❑ Rheumatoid Arthritis ❑ Gout ❑ Lupus ❑ Myopathy

CANCER HISTORY

❑ Breast ❑ Prostate ❑ Lung ❑ Thyroid ❑ Colon ❑ Kidney ❑ Myeloma ❑ Lymphoma

❑ Skin Cancer ❑ Other _____

PAST SURGICAL HISTORY

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

SOCIAL HISTORY

Do you use tobacco? ❑ Y ❑ N Packs per day: _____ Years of Use: _____

Do you use alcohol? ❑ Y ❑ N ❑ Daily ❑ Weekly

Marital History: ❑ Single ❑ Married ❑ Divorced ❑ Widow

Employment: ❑ Student ❑ Disabled, how long: _____ ❑ Occupation: _____ Duration: _____

FAMILY HISTORY

❑ Diabetes ❑ Heart Disease ❑ High Blood Pressure ❑ Blood Clotting Problems ❑ Arthritis ❑ Cancer: _____

REVIEW OF SYMPTOMS

❑ Chest Pain ❑ Constipation ❑ Abnormal Bleeding ❑ Abnormal Menstrual Cycle ❑ Cough ❑ Depression

❑ Cold Hands/Feet ❑ Growth Disturbance ❑ Incontinence Bowel ❑ Incontinence Urine ❑ Loss of Appetite

❑ Ear Pain ❑ Muscle Weakness ❑ Numbness Feet ❑ Numbness Hands ❑ Sleep Disturbance ❑ Fainting

❑ Impotence ❑ Sputum Production ❑ Fever ❑ Balance Problems ❑ Shortness of Breath ❑ Visual Disturbance

❑ Mania ❑ Seizures ❑ Sore Throat ❑ Swelling in the Legs ❑ Skin Rash ❑ Skin Ulcers ❑ Wheezing

❑ Unexplained Weight Loss ❑ Vomiting ❑ Stomach Pain ❑ Weight Gain

CURRENT MEDICATIONS: _____

_____

MEDICATION ALLERGY: ❑ Y ❑ N List: _____

_____ _____

Physician Signature Date

_____ _____

Patient Signature Date