CENTRAL ORTHOPEDIC GROUP, LLP

NI / FU PATIENT UPDATE ACCOUNT #_____

DATE _____ MD _____ PLV RVC MASS

NAME: _____DOB_____ ACCT# _____

HOME #: _____CELL #_____ EMAIL:_____

IS THERE AN ADDRESS CHANGE: ____ YES ____ NO IF YES PLEASE WRITE BELOW:_____

_____

HAS THERE BEEN ANY CHANGE IN YOUR MEDICAL INSURANCE? YES _____ (OR) NO _____

INSURANCE _____ ID # _____ POLICY HOLDER_____

____ YES ____ NO **HAVE THERE BEEN ANY CHANGES IN YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT? IF YES, PLEASE DESCRIBE _____**

_____

____ YES ____ **NO HAVE YOU BEEN HOSPITALIZED FOR ILLNESS OR INJURY SINCE YOUR LAST VISIT?**

PLEASE DESCRIBE:_____

PRIMARY PHYSICIAN:_____REFERRING PHYSICIAN:_____

BODY PART (S) TREATING: _____ **RIGHT / LEFT**

PHARMACY NAME: _____LOCATION:_____

____ YES ____ NO **ARE YOU TAKING OR HAVE YOU TAKEN ANY MEDICINE REGULARLY NOT LISTED IN YOUR PREVIOUS HISTORY? (PREVIOUS HISTORY AVALIBLE UPON REQUEST) PLEASE LIST MEDICATIONS**:_____

_____

____ YES ____ NO **HAVE YOU DISCONTINUED ANY MEDICATION SINCE YOUR LAST VISIT. PLEASE LIST** _____

_____

____ YES ____ NO **ARE YOU HAVING ADDITIONAL DIFFICULTY OR ARE YOU EXPERIENCING SYMPTOMS RELATED TO THIS CONDITION SINCE YOUR LAST VISIT? PLEASE DESCRIBE: _____**

_____

____ YES ____ NO **HAVE YOU BEEN DIAGNOSED WITH ANY ALLERGIES NOT LISTED IN YOUR PREVIOUS HISTORY?**

(PREVIOUS HISTORY AVAILABLE UPON REQUEST) PLEASE LIST:_____

____ YES ____ NO **ARE YOU PREGNANT OR IS THERE ANY CHANCE OF YOU BEING PREGNANT?**

_____

PATIENT SIGNATURE: _____PARENT /GUARDIAN SIGNATURE: _____

DOCTORS SIGNATURE: _____DATE: _____

PLV: RVC: MASS:

FU / NI / NP **DATE _____** **MD _____** **Account #_____**

Note: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

LAST NAME _____ FIRST NAME _____ MI:_____

DATE OF BIRTH _____ AGE_____ TELEPHONE:_____EMAIL:_____

CHIEF COMPLAINT: WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)

_____

IS THIS WORK RELATED: YES / NO **IS THIS CAR RELATED:** YES / NO **DATE OF INJURY:_____**

DESCRIBE _____**DURATION OF SYMPTOMS**:_____

XRAYS TAKEN YES / NO **FACILITY** _____ **DATE** _____ **DO YOU HAVE FILMS** YES / NO

WERE MRI/CT TAKEN YES / NO **FACILITY** _____ **DATE** _____ **DO YOU HAVE FILMS** YES / NO

WERE YOU TREATED IN THE HOSPITAL YES / NO **URGENT CARE** YES / NO **ANOTHER DOCTOR** YES / NO

ADDRESS WHERE TREATED:_____

PHARMACY: _____ ADDRESS:_____TOWN:_____

LOCATION OF PAIN OR PROBLEM: _____ RIGHT / LEFT

ON WHAT SCALE IS YOUR PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

(0=NO PAIN 10 = EXTREME PAIN)

IS YOUR PAIN DULL / SHARP / ALWAYS THERE
EXPLAIN:_____

ANYTHING ELSE OCCURING AT THE SAME TIME? YES/ NO

If yes, **DESCRIBE**_____ _____

DOES THE PROBLEM INTERFERE WITH YOUR NORMAL FUNCTIONS: YES / NO
DESCRIBE:_____

IS THERE ANYTHING THAT HELPS TO RELIEVE THE PAIN
DESCRIBE:_____

RIGHT HANDED / LEFT HANDED / AMBIDEXTTROUS CIRCLE ONE

DAILY ASPIRIN: YES / NO **BLOOD THINNERS:** YES / NO

POSSIBILITIES OF BEING PREGNANT: YES / NO **ORAL CONTRACEPTIVES:** YES / NO

FAMILY HISTORY: ILLNESS IN IMMEDIATE FAMILY:

_____**RELATIONSHIP**:_____

_____**RELATIONSHIP:**_____
_____**RELATIONSHIP:**_____

MD	NOTES

OVER

ACCOUNT#:_____

DO YOU SMOKE: YES / NO **HOW MUCH**: _____ **DO YOU LIVE ALONE**: YES OR NO

DO YOU DRINK: YES / NO **HOW MUCH**:_____ **OCCUPATION**:_____

MAJOR SURGERIES: ☐ None **IF YES, PLEASE LIST:**_____

_____

ALLERGIES: _____ ☐ None

MEDICAL PROBLEMS: ☐ None **MEDICATIONS:** ☐ None

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS? CIRCLE CORRECT RESPONSE AND EXPLAIN IN SPACE PROVIDED BELOW.

CARDIOVASCULAR: ☐ None
CHEST PAIN
VARICOSE VEINS
HYPERTENSION
DEFIBRILLATOR /PACEMAKER
STENTS
OTHER:_____

CONSTITUTIONAL: ☐ None
FEVER:
CHILLS:
HEADACHE
OTHER:_____

EYES: ☐ None
BLURRED VISION
DOUBLE VISION
EYE PAIN
OTHER:_____

GASTROINTESTIONAL: ☐ None
ABDOMINAL PAIN
HISTORY OF ULCERS
INDIGESTION/HEARTBURN
NAUSEA/VOMITING
OTHER_____

GENITOURINARY: ☐ None
URINE RETENTION
PAINFUL URINATION
URINARY FREQUENCY
OTHER:_____

HEMATOLOGIC/LYMPHATIC: ☐ None
BLOOD CLOTTING PROBLEM
SWOLLEN GLANDS
OTHER: _____

INTEGUMENTARY: ☐ None
SKIN RASH
BOILS
PERSISTENT ITCH
OTHER: _____

MUSCULOSKELETAL: ☐ None
JOINT PAIN
NECK PAIN
BACK PAIN
OTHER: _____

NEUROLOGICAL: ☐ None
TREMORS
DIZZY SPELLS
NUMBNESS / TINGLING
OTHER: _____

PSYCHOLOGICAL: ☐ None
HISTORY OF DEPRESSION
SLEEP DISTURBANCES
ANXIETY DISORDER
OTHER: _____

RESPIRATORY: ☐ None
WHEEZING
FREQUENT COUGH
SHORTNESS OF BREATH
OTHER: _____

PATIENT SIGNATURE/GUARANTOR: _____DATE:_____

PHYSICIANS SIGNATURE:

_____DATE:_____

VITALS TO BE COMPLETED BY
BMI _____
TEMP _____
HEIGHT _____
WEIGHT _____

MA INITIAL _____

← **OVER**