INSALL SCOTT KELLY

Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

PATIENT INFORMATION		
Patient Name:		**Date:**
DOB:	**Height:**	**Weight:**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? _____

II. Which side is affected? ○ Right ○ Left ○ Bilateral

III. Date of Injury or start of pain: _____

How did the pain occur? ○ Injury ○ Chronic ○ Spontaneous

Is this work related? ○ Yes ○ No

Is this the result of a motor vehicle accident? ○ Yes ○ No

IV: Pain Description

Quality of your pain? ○ Mild ○ Moderate ○ Severe

Type of pain? ○ Sharp ○ Dull ○ Other: _____

Have you had physical therapy? ○ Yes ○ No

Are you taking any pain medications?

Anti-inflammatory agent ○ Yes ○ No Drug Name: _____

Pain Medication ○ Yes ○ No Drug Name: _____

Tylenol ○ Yes ○ No

Have you been putting ice on the area? ○ Yes ○ No

Have you had any testing? ○ Yes ○ No

Which tests? ☐ X-Ray ☐ MRI ☐ EMG/NCS ☐ Bone Scan ☐ CT Scan

Medical History

Osteoporosis	○ Yes	○ No	Cancer	○ Yes	○ No
Hypertension	○ Yes	○ No	Prolonged Steroid Treatment	○ Yes	○ No
Diabetes	○ Yes	○ No	Degenerative Joint Disease	○ Yes	○ No
Arthritis	○ Yes	○ No	Degenerative Disk Disease	○ Yes	○ No

Social History

Do you smoke cigarettes? ○ Yes ○ No

How long have you smoked? ○ >1 year ○ 1-10 years ○ 10+ years

How many packs per day? ○ >1 pack ○ 1-2 packs ○ 3+ packs

Have you ever smoked cigarettes in the past? ○ Yes ○ No

Do you drink alcohol regularly? ○ Yes ○ No

How many drinks per day? ○ 1 drink ○ 2-3 drinks ○ 4+ drinks

Do you have a history of substance abuse? ○ Yes ○ No

Have you ever had a blood transfusion? ○ Yes ○ No

Do you participate in sports/recreational activities? ○ Yes ○ No

Family History

Mother	○ Cancer	○ Osteoporosis	○ DJD	○ Arthritis
Father	○ Cancer	○ Osteoporosis	○ DJD	○ Arthritis
Paternal Grandmother	○ Cancer	○ Osteoporosis	○ DJD	○ Arthritis
Paternal Grandfather	○ Cancer	○ Osteoporosis	○ DJD	○ Arthritis
Maternal Grandmother	○ Cancer	○ Osteoporosis	○ DJD	○ Arthritis
Maternal Grandfather	○ Cancer	○ Osteoporosis	○ DJD	○ Arthritis

Review of Systems: *Are you experiencing any of these issues now?*

Constitutional

Fatigue	○ Yes	○ No
Weight change	○ Yes	○ No
Fever	○ Yes	○ No

Neurological

Migraine Headaches	○ Yes	○ No
Numbness/ Tingling	○ Yes	○ No
Seizures	○ Yes	○ No
Dizziness	○ Yes	○ No

Respiratory

Shortness of Breath	○ Yes	○ No
Trouble Breathing	○ Yes	○ No
Wheezing/ Asthma	○ Yes	○ No
Chronic Coughing	○ Yes	○ No

Cardiovascular

Chest Pain	○ Yes	○ No
Irregular Heartbeat	○ Yes	○ No
High Blood Pressure	○ Yes	○ No
Leg/Ankle swelling	○ Yes	○ No

Musculoskeletal

Joint pain	○ Yes	○ No
Joint stiffness	○ Yes	○ No
Joint swelling	○ Yes	○ No
Back Pain	○ Yes	○ No

Gastrointestinal

Nausea/ Vomiting	○ Yes	○ No
Stomach Ulcer	○ Yes	○ No
Diarrhea	○ Yes	○ No
Blood in stool	○ Yes	○ No

Skin

Rashes/sores	○ Yes	○ No
Skin Cancer	○ Yes	○ No
Itching/ Burning	○ Yes	○ No

Hematologic

Anemia	○ Yes	○ No
Easy Bruising	○ Yes	○ No
Bleeding problem	○ Yes	○ No

Other

Sexually Transmitted Diseases ○ Yes ○ No

Allergies

Are you allergic to any medications? ○ Yes ○ No If yes, please list:_____

Are you allergic to food or environmental substances? ○ Yes ○ No If yes, please list:_____

Medications (Please list name of medication and dosage)	

Hospitalization (Please list)	Surgeries (Please list surgery type and year)

Patient Signature _____ **Date** _____