EMORY ORTHOPAEDICS CENTER

NEW PATIENT INFORMATION FORM

Please print all information. All blanks must be filled to allow us to serve you quickly and efficiently.
Thank you for your cooperation.

Date: ______________________ Date of Birth: ______________________

Patient Name: ______________________

Address: ______________________

____

Phone: Home: ( ) ______________________ Work: ( ) ______________________

How were you referred to The Emory Spine Center: ❒ Physician ❒ Patient / Friend ❒ Health Connection

❒ Workers Comp ❒ Emory Reputation ❒ Insurance ❒ Radio / TV Advertisement ❒ Other: __________

Referring Physician or Referral Source: ______________________

Address: ______________________

City: ______________________

Phone: ( ) ______________________ Fax: ( ) ______________________

Do you want your medical records sent to this physician? ❒ Yes ❒ No

Primary Doctor: ______________________

Address: ______________________

City: ______________________

Phone: ( ) ______________________ Fax: ( ) ______________________

Do you want your medical records sent to this physician? ❒ Yes ❒ No

Are there any other physicians to whom you would like your medical records sent?
(Please include name and address)

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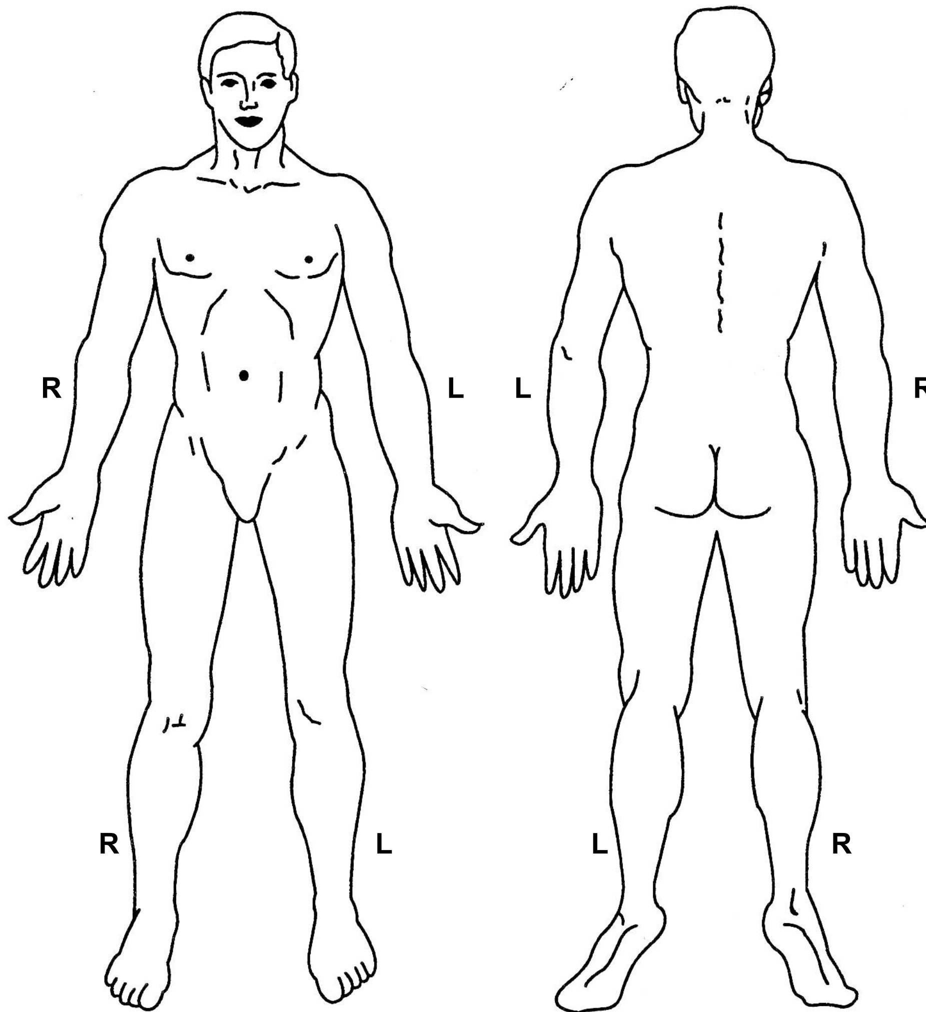
ORTHO PAIN CHART

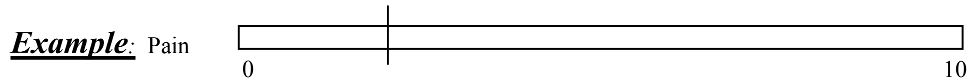
Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

Numbness =	= = = = = = = = =	Pin & Needles =	o o o o o o o o o	Burning Aching =	x x x x x x x x x	Stabbing =	/ / / / / / / / / / / /



Please indicate your current pain level by placing a line below with “0” = no pain and “10” = worst pain imaginable.

Example: Pain



Pain at its Worst

0 10

Pain at its Best
(lying down, resting)

0 10

Pain on Average

0 10

HISTORY OF PRESENT COMPLAINT

1. Age: __________ 2. ❒ Male ❒ Female 3. ❒ Right Handed ❒ Left Handed

4. Where is your problem located? ❒ Left side ❒ Right side
   ❒ Neck ❒ Upper Back ❒ Arm/Elbow ❒ Shoulder ❒ Wrist/Hand
   ❒ Lower Back ❒ Hip ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

5. How long have you had this problem? ____________________________ Since? ______/_______/______ (month / day / year)

6. Briefly, please give the details of how this problem originally started:

____

____

____

____

7. Was this from a work-related injury? ❒ No ❒ Yes - Is it under workers compensation ❒ No ❒ Yes
   Have you missed any work because of this problem? ❒ No ❒ Yes, how much? ___________________________

8. Please describe your present pain now (what you feel, where, when, etc.):

____

____

____

9. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present problem: (Check one of each)

	Which type	**Helpful**	**No Help**	**Not Used**
Antiinflammatory	____________________	❒	❒	❒
Muscle Relaxants	____________________	❒	❒	❒
Narcotic Pain Medications	____________________	❒	❒	❒
Hot Packs	____________________	❒	❒	❒
Ice	____________________	❒	❒	❒
Ultrasound	____________________	❒	❒	❒
Physical Therapy Treatment	____________________	❒	❒	❒
Cortisone Injection	____________________	❒	❒	❒
Trigger Point Injection	____________________	❒	❒	❒
Brace/Splint	____________________	❒	❒	❒
Chiropractor	____________________	❒	❒	❒
Acupuncture	____________________	❒	❒	❒
Other: ____________________	____________________	❒	❒	❒

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PAST HISTORY

10. Please indicate whether you have had any of the following studies for **this problem**:

	YES	NO	WHEN/WHERE		YES	NO	WHEN/WHERE
Regular X-ray	❐	❐	__________________	CT Scan	❐	❐	__________________
EMG	❐	❐	__________________	MRI	❐	❐	__________________

11. Have you had surgery for **this problem** in the past: (Check one) ❐ Yes ❐ No How many times?__________

What was the date(s) of the most recent surgery? __________ , _________ , _________

Did you improve from the surgery procedure(s)? ❐ **Yes** ❐ No

12. Have you had any past episodes of similar pain or injury? ❐ Yes ❐ No (please describe)

____

____

____

SOCIAL HISTORY

13. Current work status: ❐ Working full duty ❐ Working restricted duty (Since__________) ❐ Retired

❐ Disabled (Since__________) ❐ Student ❐ Homemaker ❐ Unemployed

Company:_______________________ Occupation: _____________________ Title:______________________

How long have you worked for this company?____

14. Marital status ❐ Single ❐ Married ❐ Divorced ❐ Widowed

15. Number of Children:___________________

16. I live: ❐ Alone ❐ With:___________________________

17. I live in a: ❐ House ❐ Apartment ❐ Assisted living ❐ Nursing home

18. Are you a cigarette smoker? ❐ Yes, now ❐ Never ❐ Quit - How long ago did you quit?__________

If you answered “yes” or “quit”, how much do or did you smoke per day?

❐ Less than ½ pack ❐ ½ pack ❐ ¾ pack ❐ 1 pack ❐ More (How many?)_______________

How old were you when you started smoking?_____________

19. Do you drink any alcoholic beverages? (Check one) ❐ None

❐ 0 to 3 drinks per month ❐ 1 to 2 drinks per day ❐ 3 to 5 drinks per day

❐ More than 5 drinks per day. How many?___________ / Alcoholic in past? ❐ Yes ❐ No

20. Have you ever had a problem with drug dependence? ❐ Yes ❐ No

21. Are there any law suits pending or contemplated related to your problem? ❐ Yes ❐ No

If yes, please give your attorney’s name and phone number:____

MEDICAL/SURGICAL HISTORY

Please choose all current and past medical conditions

❒ No medical problem
❒ High blood pressure
❒ Heart attack
❒ Heart failure
❒ Abnormal heart rhythm
❒ Lung disease
❒ Tuberculosis
❒ Asthma
❒ Bronchitis
❒ Emphysema
❒ Liver disease
❒ Hepatitis

❒ Diabetes
❒ Thyroid disease
❒ Stomach ulcers / ❒ Gastric Reflux
❒ Irritable bowel
❒ Stroke
❒ Seizures
❒ Cancer – where? ____________________
❒ Kidney Failure
❒ Kidney Stones
❒ Osteoporosis
❒ Osteoarthritis
❒ Rheumatoid arthritis

❒ Bleeding disorders
❒ Anemia
❒ Blood clots in legs/lung
❒ Endometriosis
❒ Ovarian cysts
❒ Anxiety
❒ Depression
❒ Schizophrenia
❒ Anorexia/bulemia
❒ Alcoholism
❒ Seen a psychiatrist
❒ HIV

Are you under a doctor's care for any other medical condition? ❒ Yes ❒ No If yes, please explain

____

Please choose all surgeries you have had

❒ Spine-Neck
❒ Spine-Lower back
❒ Brain
❒ Heart / ❒ Pacemaker / ❒ IV Filter
❒ Angioplasty / ❒ Stent
❒ Lung
❒ Gallbladder / ❒ Stomach

❒ Appendix / ❒ Intestine
❒ Hernia / ❒ Colon / ❒ Rectum
❒ Hysterectomy / ❒ C-section / ❒ Female
❒ Kidneys / ❒ Bladder / ❒ Urinary
❒ Prostate
❒ Shoulders / ❒ Arms / ❒ Hands **> Describe** ____________________
❒ Hips / ❒ Knees / ❒ Legs / ❒ Feet **> Describe** ____________________

❒ Eyes
❒ Ears
❒ Nose
❒ Throat / ❒ Tonsils
❒ Other ____________________

List All Allergies	
Substance	**Reaction**

List All Current Medications	
Name	**Dose**

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FAMILY HISTORY

What illnesses run in your close family (other than yourself)?

- ❒ Scoliosis
- ❒ Spine disease
- ❒ Arthritis
- ❒ Heart disease
- ❒ High blood pressure
- ❒ Diabetes
- ❒ Cancer
- ❒ Bleeding disorder
- ❒ Mental illness
- ❒ Alcoholism
- ❒ Kidney disease
- ❒ Other:________________

____

____

____

REVIEW OF SYSTEMS

Please check off any current or recent problems you have

GENERAL
- ❒ Unexplained weight loss
- ❒ Appetite change
- ❒ Fevers or chills
- ❒ Night sweats
- ❒ Marked fatigue
- ❒ Difficulty sleeping

EAR, NOSE, THROAT
- ❒ Difficulty swallowing
- ❒ Hoarseness
- ❒ Loss of hearing
- ❒ Ear pain
- ❒ Nosebleeds
- ❒ Gum trouble

EYES
- ❒ Glasses
- ❒ Change of vision

CARDIOVASCULAR
- ❒ Heart or chest pain
- ❒ Abnormal heartbeat
- ❒ Poor heart function
- ❒ Ankle Swelling

LUNG
- ❒ Morning cough
- ❒ Shortness of breath
- ❒ Productive cough or sputum

DIGESTIVE
- ❒ Nausea or vomiting
- ❒ Stomach pain or ulcers
- ❒ Heartburn/acid stomach
- ❒ Frequent diarrhea
- ❒ Frequent constipation
- ❒ Uncontrolled loss of stool
- ❒ Blood in stool
- ❒ Hemorrhoids

SKIN
- ❒ Frequent rashes
- ❒ Frequent itchiness
- ❒ Easy bruising
- ❒ Swollen ankles

NEUROLOGICAL
- ❒ Seizures
- ❒ Blackouts/fainting
- ❒ Tremor
- ❒ Headaches/migraines

MUSCULOSKELETAL
- ❒ Joint Pains
- ❒ Joint Swelling
- ❒ Back Pain
- ❒ Neck Pain
- ❒ Muscle Aches

GENITOURINARY
- ❒ Burning on urination
- ❒ Difficulty starting urination
- ❒ Incontinence
- ❒ Pelvic pain
- ❒ Urinate at night more than once
- ❒ Unable to completely empty bladder

PSYCHIATRIC
- ❒ Depression
- ❒ Nervous exhaustion
- ❒ Anxiety
- ❒ Paranoia
- ❒ Obsessive/compulsive behavior