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)

Reset Form

Print Form

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** _____