Date:_____

AOA Patient Information

Last Name:_____ First Name:_____ AKA:_____

Date of Birth: _____-_____-_____ Sex: **O** Male **O** Female Marital Status :_____

Race: _____ Ethnicity: _____ Preferred language: _____

Social Security Number: _____-_____-_____ E-mail Address: _____

_____ _____ _____

Preferred contact number Home Phone Cell Phone

Preferred Confirmation Method (**Choose One**): CALL TEXT EMAIL

_____

Patient Address City State Zip Code

_____

Mailing Address if different City State Zip Code

Primary Care Physician: _____ Referring Physician: _____

Pharmacy for eRX: _____ Responsible Party Name: _____

Emergency Contact

_____

Last Name First Name Relationship DOB

_____

Home Phone Work Phone Cell Phone

Does the emergency contact have permission to make Medical Decisions? **O** YES **O** NO

PRIMARY INSURANCE Please Fill out **ALL** Your Insurance Information

Carrier:_____ Effective Date:_____/_____/_____

_____

Name of Policy Holder: Last Name First Name D.O.B Relationship to Patient

_____

Insurance ID Number Group ID Number SSN

SECONDARY INSURANCE

Carrier:_____ Effective Date:_____/_____/_____

_____

Name of Policy Holder: Last Name First Name D.O.B. Relationship to Patient

_____

Insurance ID Number Group ID Number SSN

SIGNED:_____ **DATE:**_____

New Problem Questionnaire

Please Check a box as appropriate

Animas Orthopedic Associates

Name: _____ Date of Birth: _____ Date: _____

1) Sex: □ Male or □ Female Height _____ Weight _____

2) Are you □ Right or □ Left Handed?

3) What brings you in today? □ Right □ Left Body Part: _____

(other important details)_____

_____

_____

4) What is your main problem?

□ Pain □ Unstable or Dislocating Joint

□ Numbness □ Swelling

□ Weakness □ Stiffness

□ Other (explain):_____

5) How did your problem start? (give details as needed)

□ Job Injury □ Sports Injury

□ Motor Vehicle Accident □ Gradual or Slow Onset

□ Other (explain):_____

6) How long have you had this problem, approximately? _____

7) Is your pain: □ Aching □ Burning □ Dull □ Piercing □ Sharp □ Throbbing

8) Is your problem:

□ Improving □ Worsening □ Staying the Same

9) Does your pain or problem awaken you from sleep? □ Yes □ No

10) Is your pain or problem intermittent? □ Yes □ No or Constant? □ Yes □ No

11) What worsens your problem? (give details as needed)

□ Exercise □ Repetitive Motions □ Nothing

□ Sitting □ Overhead Activities □ Rest

□ Standing □ Going up and down stairs □ Walking

□ Other (explain):_____

12) What helps your problem? □ Brace □ Elevation □ Heat □ Ice □ Injection □ Massage □ Pain meds □ NSAIDs □ Physical therapy □ Rest □ Stretching □ Nothing Other (explain):_____

13) Are routine activities or walking limited because of your problem? □ Yes □ No

14) Do you use any assistive devices? □ Cane □ Walker □ Wheelchair □ Other: _____

15) What tests have you had?

□ X-rays □ Nerve Test (EMG or NCV)

□ CT Scan or MRI □ Ultrasound □ Other: _____

17) What medicines are you taking for this problem? _____

18) Are you on or applying to any of the following programs because of your problem?

□ Disability □ Worker's Compensation

19) What is your occupation? _____

20) What is your present work status?

□ Not Working Date last worked: _____

□ Light Duty For how long? _____

□ Regular Duty, no restrictions

21) If you are working, does your job require the following?

□ Lifting How Many Pounds: _____ □ Extended Walking

□ Frequent Bending & Lifting □ Continuous Standing

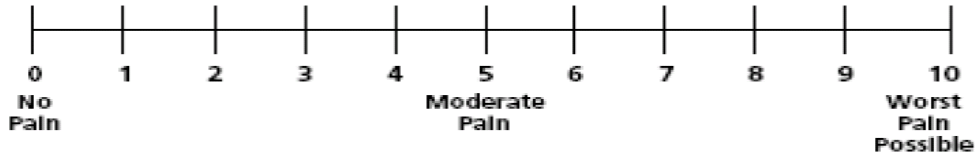
□ Frequent Squatting or Kneeling □ Sitting

□ Climbing □ Repetitive Motions

22) Any other acute problems in your life right now or anything else regarding your problem that you wish us to know? _____

23) Please make a mark on the scale regarding the severity of your problem.

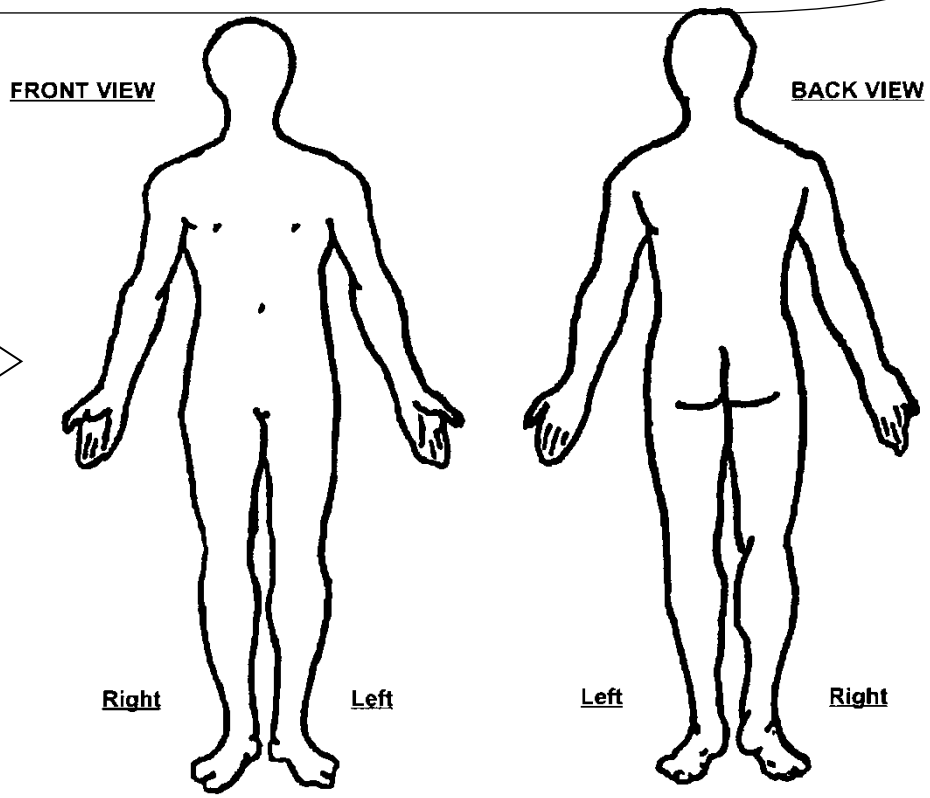
24)



Mark the area(s) on your body where you feel the sensations described below, using the appropriate symbol. Include all pertinent areas and radiating pain.

○ *Ache* / *Sharp Pain* Δ *Burning or Tingling* # *Numbness*

To complete the picture, draw in your face and place an "**X**" where the pain is worst now



X_____ _____ X_____

Signature of Patient, Parent, or Guardian Date Reviewed by MD

Animas Orthopedic Associates

General Medical History Worksheet

Check boxes and fill in information as appropriate

Name: _____ Date of Birth: _____ Date: _____

Who are your primary doctor(s) to whom reports should be sent? _____

Past Medical History

☐ Diabetes/High Blood Sugar	☐ High Blood Pressure	☐Heart Attack/Heart Disease	☐ Lung Disease/Emphysema (explain): _____
☐ Arthritis	☐ Sleep Apnea	☐ Gout	☐ Prior Fractures/Broken Bones (explain): _____
☐ Varicose Veins	☐ Thyroid Disease	☐ Psychiatric Problems	☐ Inflammatory Arthritis (Rheumatoid, Lupus, Psoriatic)
☐ Fibromyalgia	☐ Stroke/T.I.A.	☐ High Cholesterol	☐ Bowel and GI Problems: (explain): _____
☐ Urinary Tract Infections	☐ Anemia/Hemophilia	☐Blood Clot/Deep Vein Thrombosis	☐Serious Infections (explain): _____
☐ HIV/AIDS	☐ Breast Disease	☐ Poor Circulation or Vascular Disease	☐ Sexually Transmitted Disease (explain): _____
☐ Prostate Disease	☐ Multiple Sclerosis	☐ Eating Disorder/Poor Nutrition	☐ Skin Disease (explain): _____
☐ Kidney Disease	☐ Anesthesia Problems	☐ Gastric Ulcers	☐Hepatitis ("Jaundice")/Liver Disease

Cancer History (type and current status): _____

Other Medical Problems: _____

Prior Hospitalizations and Surgical History

☐ No Past Medical History

	Type of Surgery/Reason for Hospitalization	Date	Surgeon/Physician
1.			
2.			
3.			
4.			
5.			

Current Medications (include herbal supplements and attach sheet if necessary)

☐ Taking No Medication

	Name of Medication	Dose/Strength	Schedule Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Allergies to Medication or Materials

☐ No Known

	Allergen	Reaction
1.		
2.		
3.		

Social Background

Marital Status: □ Married □ Domestic Partnership □ Single □ Divorced □ Widowed
Age(s) of children: _____ Can someone care for you at home? □ No □ Yes, who? _____
Do you drink caffeinated beverages? □ No □ Yes If so, how much per day? _____
Do you have a history of illicit drug use? □ No □ Yes If so, explain: _____
Do you use tobacco? □ No □ Yes If so, how much/packs per day? _____ How many years? _____
Previously used tobacco? □ No □ Yes If so, did you quit □ 1 year ago □ >5 years ago □ >10 years ago
Do you drink alcohol? □ No □ Occasionally □ Daily How much? _____

Family Medical History

Relation	Age	State of Health	Age of Death	Medical Problems/Cause of Death
Mother				
Father				
Siblings □ Bro □Sis				
Siblings □ Bro □ Sis				
Siblings □ Bro □ Sis				
Grandfather (maternal)				
Grandmother (maternal)				
Grandfather (paternal)				
Grandmother (paternal)				

Review of Systems: Are you currently having, or have you had a problem with:

Condition	Check a Box	Please Describe all "Yes" Responses
Fever or Shaking Chills	□ No □ Yes	
Weight Loss (not diet related)	□ No □ Yes	
Chest Pain	□ No □ Yes	
Lung or Breathing Problems	□ No □ Yes	
Irregular Heartbeat	□ No □ Yes	
Problems Urinating	□ No □ Yes	
Loss of Strength or Numb/Tingling	□ No □ Yes	
Bowel or Stool Problems	□ No □ Yes	
Headaches	□ No □ Yes	
Vision Problems	□ No □ Yes	
Skin Issues	□ No □ Yes	
Pregnancy or Menstrual Problems	□ No □ Yes	
Lumps or Masses (incl. breast)	□ No □ Yes	
Fainting/Seizures/Blackout	□ No □ Yes	
Bleeding or Blood Clots	□ No □ Yes	
Psychiatric Issues	□ No □ Yes	
Problems with Anesthesia	□ No □ Yes	
Ears, Nose or Throat	□ No □ Yes	

X_____ _____ **X**_____
Signature of Patient, Parent, of Guardian Date Reviewed by MD