



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

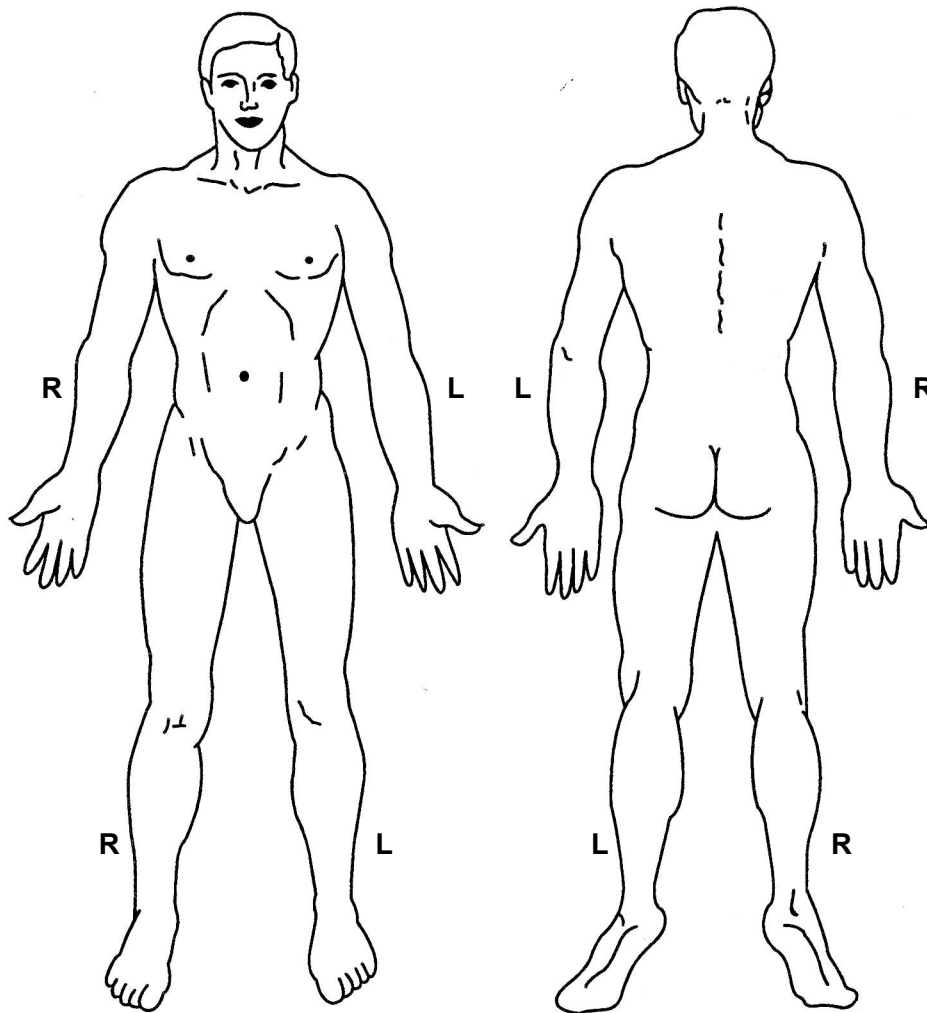
Are there any other physicians to whom you would like your medical records sent?
(Please include name and address)

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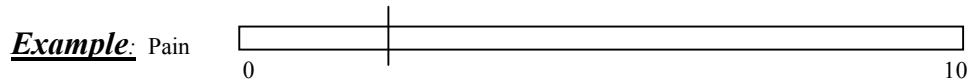
ORTHO PAIN CHART

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 =	ooo	Burning =	xxx	Stabbing =	////
	===		ooo	Aching =	xxx		////
	===		ooo		xxx		////



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



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)

	<u>Which type</u>	Helpful	No Help	Not Used
Antiinflammatory	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxants	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic Pain Medications	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Packs	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy Treatment	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigger Point Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace/Splint	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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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	<input type="checkbox"/>	<input type="checkbox"/>		CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	
EMG	<input type="checkbox"/>	<input type="checkbox"/>		MRI	<input type="checkbox"/>	<input type="checkbox"/>	

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

- | | | |
|--|---|---|
| <input type="checkbox"/> No medical problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stomach ulcers / <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Blood clots in legs/lung |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer – where? _____ | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Anorexia/bulemia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Seen a psychiatrist |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> 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

- | | | |
|--|---|--|
| <input type="checkbox"/> Spine-Neck | <input type="checkbox"/> Appendix / <input type="checkbox"/> Intestine | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Spine-Lower back | <input type="checkbox"/> Hernia / <input type="checkbox"/> Colon / <input type="checkbox"/> Rectum | <input type="checkbox"/> Ears |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Hysterectomy / <input type="checkbox"/> C-section / <input type="checkbox"/> Female | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Heart / <input type="checkbox"/> Pacemaker / <input type="checkbox"/> IV Filter | <input type="checkbox"/> Kidneys / <input type="checkbox"/> Bladder / <input type="checkbox"/> Urinary | <input type="checkbox"/> Throat / <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Angioplasty / <input type="checkbox"/> Stent | <input type="checkbox"/> Prostate | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Shoulders / <input type="checkbox"/> Arms / <input type="checkbox"/> Hands > Describe _____ | |
| <input type="checkbox"/> Gallbladder / <input type="checkbox"/> Stomach | <input type="checkbox"/> Hips / <input type="checkbox"/> Knees / <input type="checkbox"/> Legs / <input type="checkbox"/> Feet > Describe _____ | |

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)?

- | | | |
|--|--|---|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Spine disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding disorder | _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness | _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Alcoholism | _____ |

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