

Thunder Basin Orthopaedics and Sports Medicine

Mark G. Murphy, MD * Joseph F. Allegretto, MD
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Today's Date: _____

Patient's Legal Name: _____ Date of Birth: _____

o known allergies or drug allergies (please check when none are known)

Allergies:	Type of Reaction: (i.e. hives, nausea)

***Do you have a Latex allergy? YES NO

Why are you seeing the doctor today? Left Right Both _____ (body part)

Is this visit for an injury? Yes No **DATE of Injury:** _____ Time of Day: _____ am pm

Where were you when the injury occurred? _____

How did the injury occur? (Please be as specific as possible.) _____

Current problem is the result of a(n): (Check all that apply)

Accident **Work Accident** Other _____

*If a result of a work accident, have you filed a claim with Workers' Comp? Yes No

*Out of state Workers' Compensation patients will be responsible for any remaining balance not covered by their Workers' Comp.
 If you are claiming Workers' Comp for Wyoming or any other state, please initial that you understand the above statement. _____

Brief description of the symptoms you are experiencing (i.e. pain, popping, swelling) _____

Current Medications:(Please include Herbal Supplements and Vitamins)

Medications:	Dose:	How Long?	Side Effects:

Have you ever had general anesthesia? YES NO

Have you ever had problems with general anesthesia? YES NO (Describe): _____

Any personal or family history of malignant hyperthermia? YES NO

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~ Patient Information and Consent ~

Please complete this entire form and present your insurance card when registering.

Last Name _____ First Name _____ MI _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Phone: _____ Cell _____ DOB _____ Age _____ Sex _____

Email _____

Marital Status _____ Social Security Number _____ Student Yes No

Primary Physician _____ Pharmacy Preference _____

How did you hear about us? _____

Referred by _____

Emergency contact not living with you _____ Phone _____

Patient's Employer

Employer _____ Full Time Part Time

Occupation _____

Address _____

City _____ State _____ Zip _____ Phone _____

Guarantor Information—Person Responsible for Medical Expenses

Name _____ Relationship _____

Social Security Number _____ Date of Birth _____ Phone _____

Mailing Address: _____

City _____ State _____ Zip _____ Phone _____

Employer _____ Full Time Part Time

Employer Phone _____

Primary Insurance

Company _____

Address: _____ City _____ State _____ Zip _____

Phone _____ Policy # _____ Group # _____

Policy Holder _____ DOB _____

Other Insurance

Company _____

Address: _____ City _____ State _____ Zip _____

Phone _____ Policy # _____ Group # _____

Policy Holder _____ DOB _____

I give the medical staff of Thunder Basin Orthopaedics permission to examine me and make recommendations while under their medical care.

Signature Relationship to Patient Date

- Please do not discuss my medical information with anyone except myself.
- I give Thunder Basin Orthopaedics permission to give information on my medical condition and treatment to:

Relationship _____

- I give permission to my employer to attend my office visit(s).
- I give TBO permission to give information and medical documentation to my employer.

Signature Patient Name Date

I acknowledge that I have been given a written copy of Thunder Basin Orthopaedics & Sports Medicine's privacy policies regarding my personal health information.

Signature Relationship to Patient Date

I have read, understand, and agree to the attached Financial Policy. I understand that the charges not covered by my insurance company, as well as applicable co-payment and deductible are my responsibility.

Signature Patient Name Date

I attest that the information that I have given is correct and true to the best of my knowledge. I hereby assign benefits to Thunder Basin Orthopaedics & Sports and authorize them to furnish health information regarding me to my insurance carrier. I understand that I am responsible for any amount not paid by my insurance.

Signature Relationship to Patient Date

THUNDER BASIN ORTHOPAEDICS & SPORTS MEDICINE

Policy Regarding Narcotic Medications

Welcome to TBO to all new patients; for all existing patients, thank you for your support and patronage for the past several years. Because of newer and stricter guidelines, imposed by the state of Wyoming and the Wyoming State Pharmacy Board, regarding the prescription use of narcotics and the documentation thereof, the physicians and other providers at TBO are compelled to provide this list of guidelines for your understanding and compliance.

1. TBO is an orthopaedic clinic facility, not an emergency room, pain clinic, or provider of urgent care. Patients are seen on a scheduled basis, but a referral is not necessary. If you have a physician who is managing your pain issues, he/she will continue to do so and you will need to advise us of this upon completion of initial paperwork. TBO will send a copy of our office notes and recommendations to that physician if you request.
2. The narcotic medications will be prescribed for **Severe Pain Issues Only**. These include patients who have suffered fractures or dislocations, undergone surgery, or have been involved recently (less than 3 months) in an acute trauma. The patient should provide the date and/or documentation of this trauma.
3. Refills for narcotic medications must be requested prior to 3 p.m., Monday through Thursday, excluding holidays. The physicians will review this request upon notice within 48 hours during the week. **In other words, you should call for a refill at least 48 hours before your supply runs out.** If you call for a refill on a Friday, it is probable that your request will not be addressed until the following Tuesday.
4. Drug seeking behavior, either documented or suspected by the physician, may be grounds for immediate restriction of all narcotic prescriptions from TBO. This behavior includes, but is not limited to: Calling after-hours for narcotic refills; receiving simultaneous narcotic prescriptions from physicians other than the staff at TBO; failure to comply with substitute, non-narcotic medications or therapies; failure to notify the physician of previous narcotic dependence/addiction; and taking pain medication in excess of the prescribed dose and regimen.
5. Refills will **NOT** be given in the case of "lost", stolen, inadvertently flushed, or otherwise destroyed medications. **Please Keep Your Prescription and/or Medication In A Safe or Otherwise Restricted Area.**
6. Under no circumstances will TBO refill narcotic medications longer than **three months**. If further narcotic management is deemed necessary—either by the patient or the physician, a referral to a pain clinic or pain management specialist will be made.
7. Benefits of the narcotic medication will be evaluated regularly using the following criteria: increase in general function, increase in life activities, improvement in pain intensity levels, possible return to work and maintenance of a job.

I, _____, have read, understand, and will comply with all of the guidelines listed above concerning narcotic medications.

Patient Signature

Date

You as the patient have the right to request a copy of this signed agreement at any time

Lumbar Initial History Form

Who referred you? _____

When did your symptoms start? _____

How did they start (MVA, fall, woke up with pain, etc.)?

Do you smoke or chew tobacco? ___ Y ___ N How much? _____

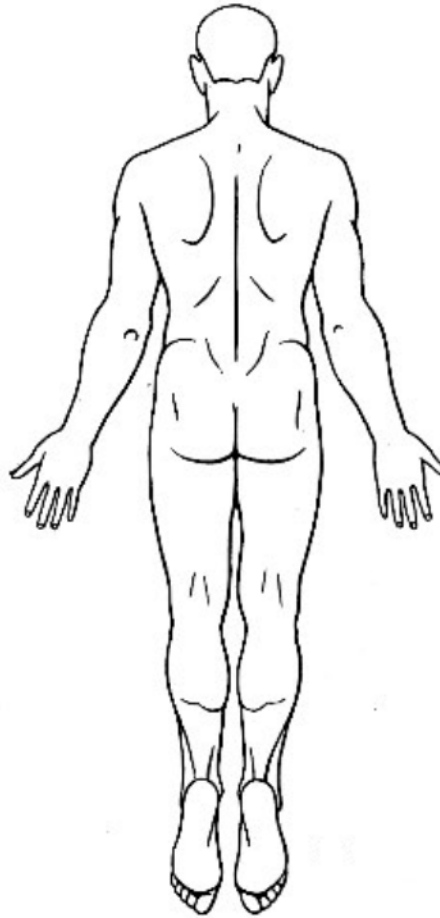
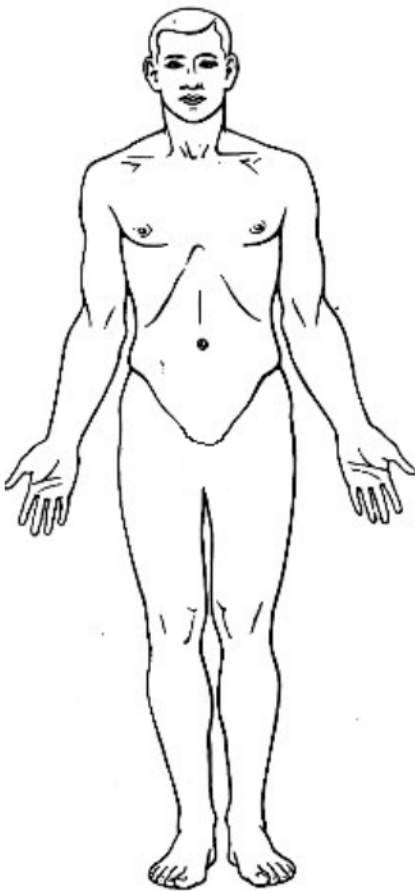
Use the following symbols to indicate on the diagrams the location and type of your symptoms. Circle the numbers that most accurately describe your pain level.

No Pain

Unbearable pain

On average

0---1---2---3---4---5---6---7---8---9---10



XXXXXXXX	Sharp / Stabbing
^^^^^^	Numbness
*****	Pins and Needles
000000	Ache
///////	Burning



At its worst

0---1---2---3---4---5---6---7---8---9---10

My symptoms are worse when I:

___ Bending forward ___ Bending backward ___ Twisting ___ Lifting ___ Sitting ___ Driving ___ Walking
 ___ Standing ___ Housework ___ Lying down ___ Other: _____

My symptoms are better when I:

Bending forward Bending backward Twisting Lifting Sitting Driving Walking
 Standing Housework Lying down Other: _____

I have tried:

Physical Therapy Chiropractor Heat Ice Massage Traction Acupuncture
 Ibuprofen Aleve Meloxicam Celebrex Naproxen Aspirin Motrin Diclofenac
 Tylenol Topicals Flexeril Baclofen Robaxin Hydrocodone Oxycodone
 Tramadol Gabapentin Lyrica
 Other: _____
 Epidurals (Location and Dates _____)
 Other injections (Types _____)

Previous spinal surgeries (Date/Procedure/Surgeon)

Other symptoms:

Fever Chills Nausea/Vomiting Sweating Night pain Weightloss Weight gain
 Bowel problems (constipation, loose stool, other) Loss of urinary control (urgency, stress, other)
 Unsteadiness with walking Falling Problems buttoning shirts Changes in handwriting

Patient History

Please answer every question

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month

Day

Year

Social History

Do you have an Advanced Directive?

(If yes, please provide a copy).

Yes

No

What is your Height?

Height	
Feet	Inches
	<input type="radio"/> 0
	<input type="radio"/> 1
	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5	<input type="radio"/> 5
<input type="radio"/> 6	<input type="radio"/> 6
<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

What is your Weight?

Weight		
Pounds		
	<input type="radio"/> 00	<input type="radio"/> 0
<input type="radio"/> 100	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 200	<input type="radio"/> 20	<input type="radio"/> 2
<input type="radio"/> 300	<input type="radio"/> 30	<input type="radio"/> 3
<input type="radio"/> 400	<input type="radio"/> 40	<input type="radio"/> 4
<input type="radio"/> 500	<input type="radio"/> 50	<input type="radio"/> 5
	<input type="radio"/> 60	<input type="radio"/> 6
	<input type="radio"/> 70	<input type="radio"/> 7
	<input type="radio"/> 80	<input type="radio"/> 8
	<input type="radio"/> 90	<input type="radio"/> 9

Marital Status

Single

Married

Separated

Divorced

Widowed

Student Status / Work Status

Part Time

Full Time

N/A

Do you Live Alone?

Yes

No

Exercise

Do you exercise regularly?

Yes

No

Type: Walking

Running

Jogging

Weight Training

Cycling

Other

Frequency per week?

1

2

3

4

5

6

7

Tobacco Use

Do you currently use tobacco products?

Current (every day)

Current (some days)

Previous

Never

How many packs per day do you (or did you) smoke?

Less than 1

1

2

3

4

Greater than 4

Do you currently use other tobacco products?

Snuff

Chewing Tobacco

Pipe

Cigar

Recreational / Street Drug Use

Yes

No

Type? Marijuana

Cocaine

Crack-cocaine

Heroin

Methamphetamine

IV Drug

How frequent?

Daily

Weekly

Monthly

Yearly

Alcohol Use

Yes

No

How frequent?

Occasional

Moderate

Heavy

Quit

YOUR Medical History

Please indicate if **YOU** have a history of the following:

- Alcohol Abuse
- Anaphylaxis
- Anemia
- Anesthetic Complication
- Anxiety Disorder
- Arthritis
- Asthma
- Autoimmune Problems
- Birth Defects
- Bladder Problems
- Bleeding Disease
- Blood Clots / DVT
- Blood Transfusion(s)
- Bowel Disease
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Depression
- Diabetes
- Growth / Development Disorder
- Heart Attack
- Heart Disease
- Heart Pain / Angina
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- HIV
- Hives
- Joint Dislocations
- Kidney Disease
- Liver Cancer
- Liver Disease
- Loose Joints
- Lung / Respiratory Disease
- Lung Cancer
- Major Traumatic Injury
- Marfan's syndrome
- Mental Illness
- Migraines
- MRSA Infection or Colonization
- Osteoporosis
- Polio
- Prostate Cancer
- Rectal Cancer
- Seizures / Convulsions
- Severe Allergy
- Sexually Transmitted Disease
- Skin Cancer
- Steroid Use
- Steven-Johnson Syndrome
- Stroke
- Suicide Attempt
- TB (Tuberculosis)
- Thyroid Problems
- Ulcer
- Other Disease, Cancer, or Significant Medical Illness
- NONE of the Above

FAMILY Medical History

Please indicate if **YOUR FAMILY** have a history of the following:
(ONLY include parents, grandparents, siblings, and children)

- Family History Unknown
- Alcohol Abuse
- Anaphylaxis
- Anemia
- Anesthetic Complication
- Arthritis
- Asthma
- Bladder Problems
- Bleeding Disease
- Blood Clots / DVT
- Breast Cancer
- Colon Cancer
- Depression
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Lung / Respiratory Disease
- Migraines
- Osteoporosis
- Rectal Cancer
- Seizures / Convulsions
- Severe Allergy
- Steven-Johnson Syndrome
- Stroke
- Thyroid Problems
- Other Cancer
- NONE of the Above
- Mother, Grandmother, or Sister developed heart disease before the age of 65
- Father, Grandfather, or Brother developed heart disease before the age of 65

If you or your family member have been diagnosed with any other illness / disease not listed on this sheet, please notify your healthcare professional at the time of your appointment.

Surgical History

Please mark all surgeries you have had

I have had no Surgeries.

- | | | | |
|---|-------------------------------------|--------------------------------------|--|
| <input type="radio"/> Anal Fissure Repair | <input type="radio"/> Sinus Surgery | <input type="radio"/> Vasectomy | <input type="radio"/> Deviated Nose Septum |
| <input type="radio"/> Appendectomy | <input type="radio"/> Tonsillectomy | <input type="radio"/> Tubal Ligation | <input type="radio"/> Abdominal Surgery |
| <input type="radio"/> Hemorrhoidectomy | <input type="radio"/> Ulcer Surgery | | |

Prostate Surgery	<input type="radio"/> TURP	<input type="radio"/> Removal		
Gallbladder Surgery	<input type="radio"/> Open	<input type="radio"/> Laparoscopic		
Colon Polyp Removal	<input type="radio"/> Open	<input type="radio"/> Colonoscopy		
Colon Removal	<input type="radio"/> Partial	<input type="radio"/> Complete		
Hysterectomy (due to cancer)	<input type="radio"/> Partial	<input type="radio"/> Complete		
Hysterectomy (not due to cancer)	<input type="radio"/> Partial	<input type="radio"/> Complete		
Spinal Fusion	<input type="radio"/> Neck	<input type="radio"/> Lower Back		
Spinal Decompression	<input type="radio"/> Neck	<input type="radio"/> Lower Back		
Dilation and Curettage (D&C)	<input type="radio"/> Single	<input type="radio"/> Multiple		
Lung Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Kidney Removal	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Cataract Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Breast Cancer Lump Removal	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Mastectomy	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Mastoidectomy	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Breast Reconstruction	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Breast Reduction	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Ovary Removal	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Hand	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Wrist	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Carpal Tunnel Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Elbow	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Arm	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Shoulder	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Rotator Cuff Repair	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Arthroscopic Shoulder Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Neck	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Back	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Hip	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Hip Fracture & Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Total Hip Replacement	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Leg	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Leg Circulation Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Knee	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Total Knee Replacement	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Arthroscopic Knee Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Ankle	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Foot	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Thyroid Removal	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Total	
Carotid Artery Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Open Inguinal Hernia Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Laparoscopic Inguinal Hernia Surgery	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	
Caesarean Section	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3 or more	
Heart Valve Replacement	<input type="radio"/> Mitral	<input type="radio"/> Aortic	<input type="radio"/> Tricuspid	<input type="radio"/> Unknown Valve
Heart Bypass Surgery	<input type="radio"/> 1 vessel	<input type="radio"/> 2 vessels	<input type="radio"/> 3 vessels	<input type="radio"/> Unknown number of vessels

If you have previously had any other surgeries not listed on this sheet, please notify your healthcare professional at the time of your appointment.