Thunder Basin Orthopaedics and Sports Medicine

Mark G. Murphy, MD * Joseph F. Allegretto, MD
Robert J. Woodruff, MD * Dan A. Nicholls, PA-C * Tristyn Richendifer, PA-C

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)

C☐ Accident *Work☐Accident 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? YESNO☐ ☐
Have you ever had problems with general anesthesia? ☐ YES ☐ NO (Describe):___________
Any personal or family history of malignant hyperthermia? YESNO ☐ ☐

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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

Cervical Initial History Form

Who referred you?
____

When did your symptoms start?
____

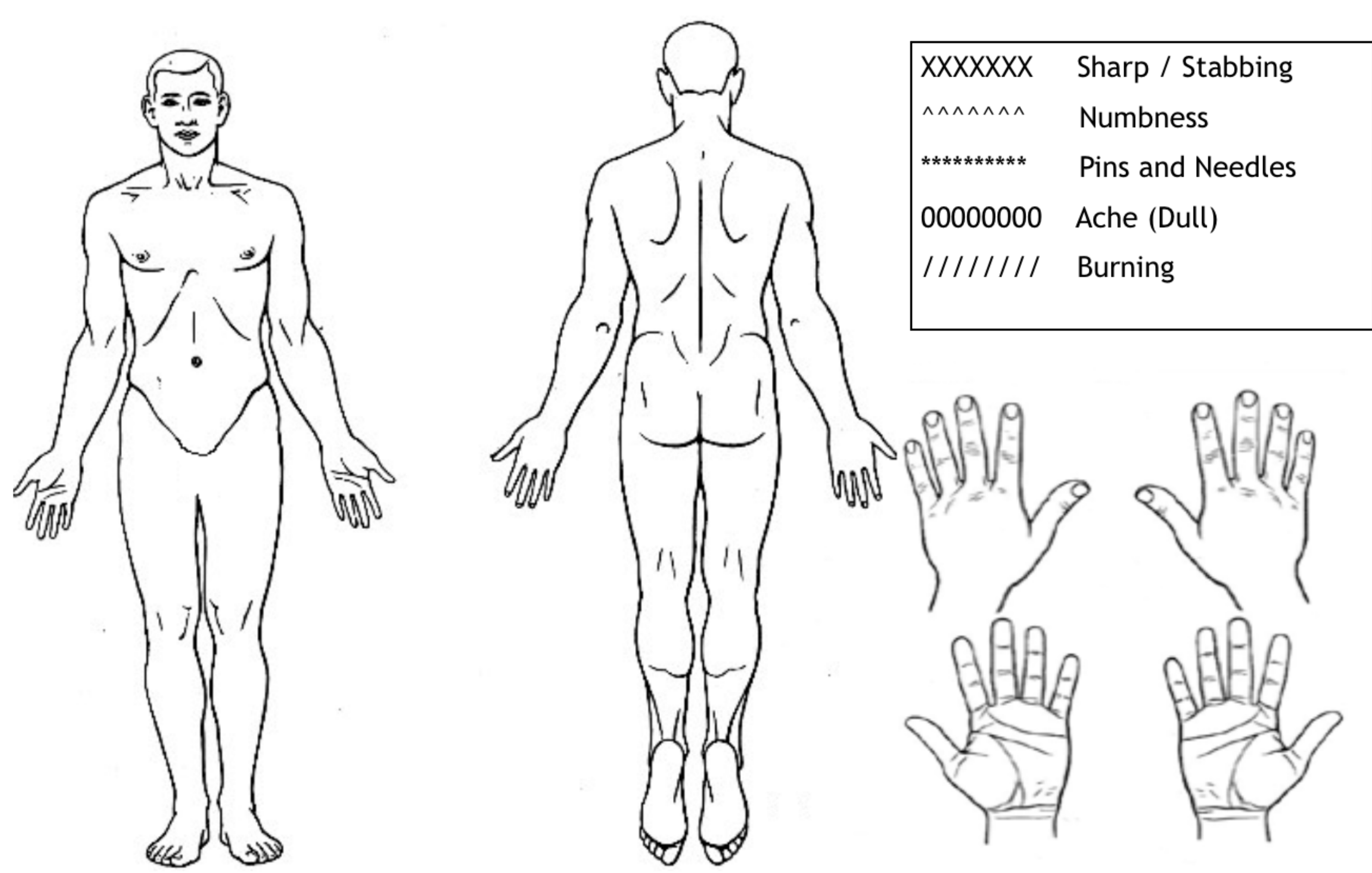
How did they start (MVA, fall, woke up with pain, etc.)?

____

____

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	

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

My symptoms are worse when I:

___ Looking up ___ Looking down___ Twisting ___ Lifting ___ Sitting___ Driving ___ Walking ___ Standing

___ Housework ___ Lying down ___ Other: ____

My symptoms are better when I:

___ Looking up ___ Looking down___ 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

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Review of Systems

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

Please mark only the symptoms you CURRENTLY are experiencing.

Mark all that apply ---- if no symptoms, please mark "**NONE**"

System				
General		fever	weight gain	
	tiredness	fatigue	persistent infections	
	night sweats	weight loss	chills	NONE
Eyes	headache	blurred vision	eye pain	
	double vision	excessive tearing	glasses/contacts	NONE
Ear, Nose, & Throat	sinus pain	hearing loss	ear discharge	
	sleep apnea	seasonal allergies	oral ulcers	NONE
Cardiovascular	chest pain	shortness of breath	swelling hands/feet	
	calf pain	palpitations	elevated blood pressure	NONE
Respiratory				
	cough	difficulty breathing	chronic cough	
	difficulty breathing on exertion	wheezing	bloody sputum	NONE
Breast	breast mass	breast pain	nipple discharge	NONE
Gastrointestinal		constipation	hemorrhoids	
	nausea	chronic diarrhea	excessive gas	
	vomiting	abdominal pain	indigestion	
	change in bowel habits	bloody stool	heartburn	NONE
Female Genitourinary (women only)				
	urinary frequency	vaginal itch or burning	incontinence	
	urinary urgency	painful urination	pelvic pain	
	urination at night	absence of menstruation	blood in urine	
	change in bladder habits	menstrual irregularities	stress incontinence	NONE
Male Genitourinary (men only)				
	painful urination	urinary urgency	testicular pain	
	change in bladder habits	impotence	blood in urine	
	urination at night	discharge	difficulty with erection	
	urinary frequency	testicular mass	incontinence	NONE
Musculoskeletal		joint stiffness	joint redness	
		joint swelling	muscle pain	
	decreased range of motion	joint pain	muscle weakness	NONE
Skin	dryness	rash	new sore/lesion	
	bruising	hives	skin ulcer	NONE
Neurologic	fainting	numbness	trouble walking	
	decreased memory	incontinence stool	seizures	
	weakness of extremities	incontinence urine	headaches	NONE
Psychiatric	anxiety	panic attack	fearful	
	change in sleep pattern	depression	hallucinations	NONE
Endocrine			cold intolerance	
	hair changes	heat intolerance	thyroid problems	
	excessive urination	excessive thirst	sexual dysfunction	NONE
Heme/Lymphatic	anemia	abnormal bleeding	blood clots	
	easy bruising	excessive bleeding	prolonged bleeding	NONE

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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**
	◯ 0
	◯ 1
	◯ 2
◯ 3	◯ 3
◯ 4	◯ 4
◯ 5	◯ 5
◯ 6	◯ 6
◯ 7	◯ 7
	◯ 8
	◯ 9
	◯ 10
	◯ 11

What is your Weight?

Weight		
	Pounds	
	◯ 00	◯ 0
◯ 100	◯ 10	◯ 1
◯ 200	◯ 20	◯ 2
◯ 300	◯ 30	◯ 3
◯ 400	◯ 40	◯ 4
◯ 500	◯ 50	◯ 5
	◯ 60	◯ 6
	◯ 70	◯ 7
	◯ 80	◯ 8
	◯ 90	◯ 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

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Patient / Family History

Please answer every question

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.

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Surgical History

Please answer every question

Surgical History

Please mark all surgeries you have had

- I have had no Surgeries.

- Anal Fissure Repair
- Appendectomy
- Hemorrhoidectomy
- Sinus Surgery
- Tonsillectomy
- Ulcer Surgery
- Vasectomy
- Tubal Ligation
- Deviated Nose Septum
- Abdominal Surgery

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

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