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**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Height:\_\_\_\_\_ft\_\_\_\_\_in Weight:\_\_\_\_\_\_\_lbs Gender:\_\_\_\_\_\_\_\_\_\_\_ Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Primary Doctor Name and City, State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Referring Doctor’s Name and City, State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*Why are you seeing the doctor today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Is this visit for an injury? Yes No **DATE of Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How long has the pain/problem been present?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the pain/problem worsened recently? No  Yes, how recently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the quality of the pain? Sharp Burning Dull Aching

How severe is the pain at the location described above? No pain Mild Moderate Severe

What makes the pain/problem better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain/problem worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the pain (*check all that apply*): Continuous Activity-related Night pain Unpredictable

Did this problem start at work? Yes No

Have you missed work because of this problem? Yes No

Have you already filed or will you file a Workers’ Compensation claim? Yes No

What treatments have you tried? I Have not tried any treatments for this problem.

|  |  |  |  |
| --- | --- | --- | --- |
| Physical Therapy/Exercise | TENS unit | Narcotic medications | Cast/boot |
| Massage/Ultrasound | Traction | Anti-inflammatories | Orthotics |
| Manipulation | Surgery | Steroid injections | Braces |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Previous physicians seen for this problem:*** I have not seen another physician for this problem.

|  |  |  |  |
| --- | --- | --- | --- |
| Physician | Specialty | City | Treatment |
|  |  |  |  |
|  |  |  |  |

Are you currently under a pain contract with another physician? No Yes. Please describe below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 ***X-rays and Tests for this problem:*** I have not had any x-rays or tests for this problem.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Results | Date | Location |
| X-Rays |  |  |  |
| MRI |  |  |  |
| CT Scan |  |  |  |
| Bone Scan |  |  |  |
| Other |  |  |  |

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Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred/Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Demographics:**  
Mailing/Physical Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Employment:**Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Full Time □ Part TimeCity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **Guarantor Information—Person Responsible for Medical Expenses**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Holder Name and Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Holder Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Holder Name and Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Holder Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent**  
Please **check** one or more of the following and **sign** below:

□ Please **do not** discuss my medical information with anyone except myself.

□ I give TBO permission to give information and medical documentation to my employer.  
Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I give Thunder Basin Orthopaedics and Sports Medicine permission to give the following person/persons information on my medical condition and treatment to:**\*Please list names below besides yourself\***

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Description automatically generated **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST MEDICAL HISTORY:** **check all that apply:**

* Heart attack
* Heart failure
* Abnormal heartbeat
* High blood pressure
* Stroke
* Blood clot in legs
* Blood clot in lungs
* Poor circulation
* High cholesterol
* Neuropathy to hands
* Neuropathy to feet
* Cancer
* Asthma
* COPD
* Emphysema
* Tuberculosis
* Thyroid
* Stomach ulcers
* Gastric reflux
* Hernia
* Kidney failure
* Kidney stones
* Rheumatoid arthritis
* Osteoarthritis
* Osteoporosis
* Gout
* Cirrhosis
* Hepatitis (A, B, or C)
* HIV/AIDS
* Bleeding disorder
* Anemia
* Depression
* ADHD
* Seizures
* Migraines
* Cerebral palsy
* Downs syndrome
* Spina bifida
* Neurofibromatosis
* Diabetes

A1C\_\_\_\_\_\_\_\_\_\_

Glucose \_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY:**

|  |  |  |
| --- | --- | --- |
| Operation: | Date: | Surgeon/Hospital: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever had general anesthesia? YES / NO

If YES, have you ever had problems related to this? YES / NO

Please explain any problems related to general anesthesia:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

**Work status:**

* Working
* Homemaker
* Unemployed
* Disabled
* On leave
* Retired
* Out on Work Comp
* Student

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital status:**

* Single
* Married
* Divorced
* Widowed

**Tobacco use:**

Are you currently smoking?

* Yes
* No

If yes, how many packs a day? \_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_

Have you quit smoking?

* Yes
* No

If yes, when did you quit? \_\_\_\_\_\_\_\_\_\_ How many years did you smoke? \_\_\_\_\_\_\_\_\_

How many packs a day did you previously smoke? \_\_\_\_\_\_\_\_\_\_

Do you use other forms of tobacco?

* Yes
* No

If yes, what forms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol use:**

* Never
* Rare
* Social
* Alcoholic
* Recovering alcoholic

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**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Illegal Drug Use:**

* Never
* In the past
* Currently - Using\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY: check all that apply**

* Heart problems
* Seizures
* Gout
* Alcoholism
* Diabetes
* Cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Kidney problems
* Lung problems
* Blood clots(legs or lungs)
* Arthritis
* High blood pressure
* Bleeding problems
* Mental illness
* Rheumatoid Arthritis
* Other Auto-immune Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS: in the past 30 days have you experienced any of the following?**

* Fever
* Chills
* Weight Loss/Weight Gain
* Fatigue
* Poor Appetite
* Rash
* Itching
* Hearing Loss
* Tinnitus
* Ear Pain
* Ear Discharge
* Nose Bleeds
* Congestion
* Sinus Pain
* Sore Throat
* Toothache/Dental Issues
* Trouble Swallowing
* Swollen Glands
* Vision Changes/Blurred
* Double Vision
* Photophobia/Light Sensitivity
* Eye Pain
* Eye Discharge
* Eye Redness
* Chest pain
* Palpitations
* Orthopnea/Hard to breathe laying down
* Lower Leg Pain
* Leg Swelling
* PND/Sleep Apnea
* Cough
* Hemoptysis/Coughing up blood
* Sputum production
* Shortness of breath
* wheezing
* Heartburn
* Nausea
* Vomiting
* Abdominal Pain
* Diarrhea
* Constipation
* Blood in stool/black stool
* Pain w Urination
* Urination Urgency
* Frequent Urination
* Blood in Urine
* Flank pain
* Muscle Pain
* Neck Pain
* Back Pain
* Joint Pain
* Falls
* Easy bruise/bleed
* Environmental/Seasonal Allergies
* Thirsty all the time
* Dizziness
* Headaches
* Tingling
* Tremor
* Sensory change
* Speech Change
* Focal weakness
* Weakness
* Seizures
* Loss of Consciousness/Blackouts
* Depression
* Suicidal ideas
* Substance abuse
* Hallucinations
* Nervous/Anxious
* Insomnia
* Memory loss
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS (prescribed and over the counter): I take no medications**

|  |  |  |
| --- | --- | --- |
| Name Of Medication | Dose | Reason |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES TO MEDICATIONS: I have no allergies**

|  |  |
| --- | --- |
| Name of Medications | Reaction (rash, swelling, stomach upset, nausea, etc) |
|  |  |
|  |  |
|  |  |