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 <u>this</u> 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 <u>this</u> problem: ☐ I have not had any x-rays or tests for this problem.

	Results	Date	Location
X-Rays			
MRI			
CT Scan			
Bone Scan			

Other			

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 Time
City _____________________________ 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 **<u>do not</u>** 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:______________________________

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	☐ Social	☐ Recovering alcoholic
☐ Rare	☐ Alcoholic	

THUNDER BASIN ORTHOPAEDICS
AND SPORTS MEDICINE

Name: ____________________________

Illegal Drug Use:

☐ Never ☐ In the past ☐ Currently - Using___________________________

FAMILY HISTORY: check all that apply

☐ Heart problems	☐ Cancer:_____________	☐ High blood pressure	☐ Other Auto-immune Disorder______________
☐ Seizures	☐ Kidney problems	☐ Bleeding problems	
☐ Gout	☐ Lung problems	☐ Mental illness	
☐ Alcoholism	☐ Blood clots(legs or lungs)	☐ Rheumatoid Arthritis	☐ Other________________
☐ Diabetes	☐ Arthritis		

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

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

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)

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 or pain clinic. 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 **<u>Severe Pain Issues Only</u>** at the provider's discretion. 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 providers will review this request upon notice within 48 hours during the week. **In other words, you should call for a refill <u>at least</u> 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 providers other than the staff at TBO; failure to comply with substitute, non-narcotic medications or therapies; failure to notify the provider of previous narcotic dependence/ addiction; and taking pain medication in excess of the prescribed dose and regimen.

5. Refills will **<u>NOT</u>** 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 **<u>three months</u>**. If further narcotic management is deemed necessary—either by the patient or the provider, a referral to a pain clinic or pain management specialist will be made.

7. Complying with Wyoming State Law, narcotic prescriptions will only be written for up to a 7 day supply at a time.

8. 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