Orthopedics and Sports Medicine, LLC

PATIENT INFORMATION SHEET

NAME_____DATE_____

NAME OF PARENT/LEGAL GUARDIAN
(IF PATIENT IS A MINOR)_____

ADDRESS_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE_____CELL PHONE_____

DATE OF BIRTH_____AGE_____ MARITAL STATUS_____

SOCIAL SECURITY#_____

EMAIL ADDRESS_____ OK TO CONTACT VIA EMAIL ? Y N

EMERGENCY CONTACT_____**PHONE**_____

REFERRING PHYSICIAN_____**PHONE**_____

PATIENT'S EMPLOYER_____

CITY_____WORK PHONE_____

ARE YOU A STUDENT?_____

PRIMARY INSURANCE _____

I.D. NUMBER_____ Group #_____

POLICY HOLDER_____DATE OF BIRTH_____RELATION_____

SECONDARY INSURANCE _____

I.D. NUMBER_____ Group #_____

POLICY HOLDER_____DATE OF BIRTH_____RELATION_____

PHARMACY INFORMATION (ALL RX'S ARE ELECTRONICALLY SENT TO YOUR PHARMACY)

NAME:_____

STREET ADDRESS:_____

PHONE NUMBER:_____

Active
Orthopaedics & Sports Medicine, LLC

MEDICAL INFORMATION SHEET

Patient Name:_____Age:_____ Date of Visit:_____

☐Female ☐Male Weight_____ Height_____ ☐Right Handed ☐ Left Handed

PRIMARY CARE PHYSICIAN'S NAME/PHONE: _____

Present Complaint:_____

When/how did this injury occur:_____

Was it related to a motor vehicle or work related injury_____

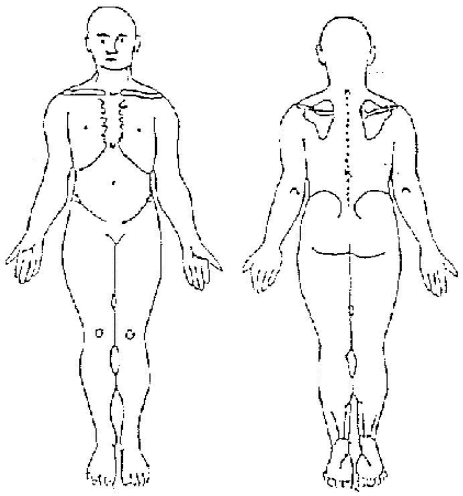
FOR PHYSICIAN USE ONLY – HISTORY OF PRESENT ILLNESS
(These are preliminary notes – refer to dictation for more details)

_____

_____

USING THE SYMBOLS BELOW, PLEASE DRAW IN THE LOCATION OF YOUR SYMPTOMS

X = Pain
O = Numbness
/ = Aching
*** = Pins and Needles**



If you have **NECK PAIN**, what percentage is
_____**%** Neck and _____% Arm (Total 100%)

If you have **BACK PAIN**, what percentage is
_____**%** Back and _____% Leg (Total 100%)

Please indicate on the scale below your level of pain. (0 meaning no pain, 10 being the worst)
Least 0___ 1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___ Worst

Please put an X in the box if the positions make your pain Better or Worse

	Worse	Better	Comments
Bending			
Bowel movement			
Coughing			
General Activity			
Home Remedies			
Lying down			
Sitting			
Standing			
Walking			

PATIENT'S NAME_____

How long can you **STAND** with no or minimal pain_____minutes

WALKING DISTANCE with no or minimal pain
☐ 0- 0-50 ft ☐ 50-200 ft ☐ 200-500 ft ☐ 500+ ft ☐1/2 mile +

Do you need **SUPPORT** to help you walk? ☐ Yes ☐ No If yes, what kind of support? _____

Do you wear a back or neck **BRACE**? ☐ Yes ☐ No If yes, what kind of brace? _____

List below the **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your main complaint.

Physician	Specialty	Dates	Treatment

Past Medical History – Please check all that apply:

☐ Asthma
☐ Recurrent Infections
☐ Bleeding Disorder
☐ Cancer Type_____
☐ Heart Disease
☐ Kidney Disease
☐ Other_____

☐ Blood Clots
☐ Ulcers
☐ Stroke
☐ Diabetes
☐ Circulation Problems
☐ Hypertension
☐ Hepatitis

☐ Osteoporosis
☐ Gout
☐ Thyroid Disease
☐ High Cholesterol
☐ Pacemaker
☐ Rheumatism
☐ HIV/Aids

PAST SURGICAL HISTORY

Type	Date	Outcome

Do you have any allergies?

☐ Antibiotics/Mediations_____
☐ Surgical Tape
☐ Iodine/Shellfish

☐ Local or general Anesthesia
☐ Seasonal allergies
☐ Other_____

CURRENT MEDICATIONS/DOSE

1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

PATIENT'S NAME_____

SOCIAL HISTORY:

Occupation: _____ **Marital Status** _____ **Education Level**_____

Work Status: ☐ Full Duty ☐ Light Duty ☐ Off Duty per Physician ☐ Unemployed ☐ Retired

If you are NOT working full duty: How Long_____
Have you had a work capacity assessment ☐ Yes ☐ No
Are you disabled through Social Security ☐ Yes ☐ No

Tobacco Use: ☐ Yes ☐ No ☐Cigarettes ☐ Cigars ☐ Chewing Tobacco (snuff)
Started Age/Year _____ Stopped ____Quantity per day:_____

Alcohol Use: Do you consume alcoholic beverages ☐ Yes ☐ No
Beer ☐ Wine ☐ Distilled Spirits ☐ Quantity per day:_____

Have you ever been treated for drug or alcohol addiction? ☐ Yes ☐ No

SIGNIFICANT FAMILY HISTORY_____

_____

REVIEW OF SYSTEMS:

CONSTITUTIONAL
☐ Weight gain – last 6 months
☐ Weight loss – last 6 months
☐ Night Sweats
☐ Chills
☐ Fever

GASTRONINTESTINAL
☐ Nausea
☐ Vomiting
☐ Dairrhea
☐ Indigestion
☐ Abdominal pain
☐ Bloody/dark stools

CARDIOVASCULAR
☐ Chest pain
☐ Palpitations
☐ Shortness of breath w/exercise
☐ Heart murmur
☐ Feet edema

EYES/EAR/NOSE/THROAT
☐ Recent changes in vision
☐ Recent changes in hearing
☐ Recent changes in smell
☐ Recent changes in taste
☐ Dizziness

GENITO-URINARY
☐ Blood in urine
☐ Urinary tract infection
☐ Unable to control bladder
☐ Unable to control bowel
☐ Rushing to go
☐ Need to go frequently

MUSCULOSKELETAL
☐ Cramps
☐ Attack of weakness
☐ Joint pain/swelling
☐ Morning stiffness

RESPIRATORY
☐ Short of breath
☐ Cough
☐ Sputum
☐ History of tuberculosis
☐ Wheezing

CENTRAL NERVOUS
☐ Poor Appetite
☐ Problem sleeping
☐ Numbness/tingling feet
☐ Numbness/tingling hands
☐ Crying spells
☐ Convulsions

SKIN
☐ Easy bleeding
☐ Any rashes
☐ Easy bruising

Who referred you to our practice?

☐ Patient ☐Primary Care Physician ☐Another Physician ☐ Insurance Plan ☐Online Directory

Patient's Signature_____

Physician's Signatue _____

Orthopedics & Sports Medicine, LLC

Michael L. Gross, M.D.
Chief, Sports Medicine Service
Hackensack Univ. Medical Center
Fellowship Trained Sports Medicine
Board Certified Orthopedic Surgery
and Sports Medicine

Oscar Vazquez, M.D.
Fellowship Trained Sports Medicine
Fellowship Trained Shoulder, Elbow Reconstruction
Board Certified Orthopedic Surgery

A. Ylenia Giuffrida, M.D.
Fellowship Trained in Hand, Upper Extremity
and Microvascular Surgery
Board Certified Orthopedic Surgery

Richard D. Rhim, M.D.
Fellowship Trained, Spine Surgery
Minimally Invasive Spinal Surgery
Board Certified Orthopedic Surgery

James C. Natalicchio, M.D.
Fellowship Trained Interventional Spine Care
Board Certified Physical Medicine
and Sports Medicine

Michael T. Benke, M.D.
Fellowship Trained, Sports Medicine
Board Certified Orthopedic Surgery

Thomas K. John, M.D.
Fellowship Trained, Total Joint Reconstruction
Board Certified Orthopedic Surgery

Ira Esformes, M.D.
Chairman, Orthopedic Surgery
Hackensack UMC at Pascack Valley
Board Certified Orthopedic Surgery
and Sports Medicine

Ralph C. Napoli, D.P.M.
Chairman, Podiatric Surgery
Hackensack UMC at Pascack Valley
Board Certified Foot, Ankle Surgery

Raghu Maddela, M.D.
Fellowship Trained, Spine Medicine
Board Certified Physical Medicine
and Rehabilitation

Michelle Joseph, P.A.
Physician Assistant

Nicole Jahn, P.A.
Physician Assistant

Sabrina Shahbahrami, P.A.
Physician Assistant

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers that may be involved in my treatment directly and/or indirectly.

- Obtain payment from third party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice or Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and that I may contact them at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may also request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions. I understand that request to forward my medical records to another treating physician other than my primary care physician must be made in writing.

Patient Name: _____

Signature: _____

Date: _____

I hereby give permission for the following to obtain any medical information on my behalf:

Name_____ Relation:_____

Name:_____ Relation:_____