Excelsior Orthopaedics, LLP

Patient Demographic Information

Name_____Date of Birth_____

Address_____
(Street) (City) (State) (Zip)

Home Phone_____Work Phone_____

Cell Phone_____SSN_____

Pharmacy Name/Location_____

Email Address(Optional)_____

Sex: ☐ Male ☐ Female **Race** *(Optional)* ☐**Caucasian** ☐**African American** ☐**Hispanic** ☐**Native American** ☐ **Alaskan Native** ☐ **Asian**

Ethnicity ☐Hispanic/Latino Origin ☐Non-Hispanic Origin ☐ Declined Primary Language_____

Primary Care Physician_____

REFERRAL SOURCE
☐Primary Care Physician ☐Family/Friend ☐Other Physician_____
☐Internet ☐Phone Book ☐TV/Radio Ad
☐Hospital ☐Urgent care
☐Other_____ ☐Athletic Trainer/School(name) _____

INSURANCE INFORMATION

Primary Insurance_____Insurance ID#_____Group#_____

Policy Holder Name (Skip if same as patient)_____DOB_____

Secondary Insurance_____Insurance ID#_____Group#_____

Policy Holder Name (Skip if same as patient)_____DOB_____

Employer Name_____Employer Address_____

Is this injury **work-related**? ☐ YES ☐NO Is this injury caused by a **motor vehicle accident**? ☐YES ☐NO

Date of Injury:_____ Date of Accident:_____

Carrier Claim Number:_____ Policy Number:_____

WCB Case Number:_____ Claim Number:_____

Location of Injury/Body Part**:**_____

RESPONSIBLE PARTY ☐*(If same as patient, check and skip to next section)*

Name_____Date of Birth_____SSN_____

Address_____
(Street) (City) (State) (Zip)

Home Phone_____Cell Phone_____Work Phone_____

Spouse/Significant Other Name_____Date of Birth_____

Emergency/HIPAA Contact_____Phone_____

Address_____Relationship to Patient_____

Past Medical History/Medical Problems/Illness Injuries

☐ **I have had NO past injuries/illnesses**

☐ **AIDS**	☐ **COPD**	☐ **Heart Attack**	☐ **Osteoporosis**
☐ **Anemia**	☐ **Diabetes (Insulin)**	☐ **Hepatitis A**	☐ **Reflux Disease**
☐ **Arthritis**	☐ **Diabetes (Noninsulin)**	☐ **Hepatitis B**	☐ **Thyroid Disease**
☐ **Rheumatoid Arthritis**	☐ **Diabetes(Gestational)**	☐ **Hepatitis C**	☐ **Tuberculosis**
☐ **Asthma**	☐ **Emphysema**	☐ **High Blood Pressure**	☐ **Stomach Ulcer**
☐ **Birth Defect**	☐ **HIV Infection**	☐ **Kidney Disease**	☐ **Cancer(s)**
☐ **Bleeding Disorder**	☐ **Heart Disease**	☐ **Lupus**	Type:_____
			☐ Current Treatment
			Type of Treatment:_____
			_____

Surgical History

☐ **I have had NO surgeries**

☐ **Arthroscopic Knee**	R	L	B		☐ **Prostate**	Removal		TURP
☐ **Arthroscopic Shoulder**	R	L	B		☐ **Rotator Cuff Repair**	R	L	B
☐ **Breast Lumpectomy**	R	L	B		☐ **Spinal Decompression**			
☐ **Carpal Tunnel Release**	R	L	B		☐ **Spinal Fusion**			
☐ **Caesarean Section**	1	2	3+		☐ **Neck Disc**			
☐ **Foot**	R	L	B		☐ **Low Back Disc**			
☐ **Hand**	R	L	B		☐ **Thyroid**			
☐ **Heart Bypass**	Bypass Graft			Artery Stenting	☐ **Total Hip Replacement**	R	L	B
☐ **Hip Fracture/Surgery**	R	L	B		☐ **Total Knee Replacement**	R	L	B
☐ **Hysterectomy**	Partial		Total		☐ **Total Shoulder Replacement**	R	L	B
☐ **Kidney Removal**	R	L	Partial	Total	☐ **Ulnar Nerve**	R	L	B
☐ **Mastectomy**	R	L	B		☐ **Vascular Surgery**			
☐ **Pacemaker**	Implant			Maintenance				

☐ **Anesthesia Complications** **Describe Previous Anesthesia Problem**_____

Assistive Devices

☐ **I use NO assistive devices**

☐ **Brace**				☐ **Crutches**			
☐ **Back Brace**				☐ **Dentures**	Full		Partial
☐ **Cane**				☐ **Hearing Aid**	R	L	B
☐ **Quad Cane**				☐ **Walker**			
☐ **Corrective Shoes**	R	L	B	☐ **Wheelchair**			

Family History/Illness

☑ (Checkmark) Indicates YES
☐ **I have NO family history** *(please proceed to next section)*
☐ **Not Known/Adopted** *(please proceed to next section)*

Please circle appropriate choice --------> (Son, Daughter, Brother or Sister)	**Father**	**Mother**	***Son/ Daughter*** **Child 1**	***Son/ Daughter*** **Child 2**	***Son/ Daughter*** **Child 3**	***Brother/ Sister*** **Sibling 1**	***Brother/ Sister*** **Sibling 2**	***Brother/ Sister*** **Sibling 3**
Deceased	☐	☐	☐	☐	☐	☐	☐	☐
Anesthesia Complication	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐
Blood Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Bladder Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Bowel Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Brain Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Cervical Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Esophagus Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Liver Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Oral Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Rectal Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Testicular Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Throat Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Cirrhosis	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐

Social History

Marital/Legal Status

☐ **Single** ☐ **Significant Other** ☐ **Widowed**
☐ **Married** ☐ **Separated** ☐ **Divorced**

Occupation_____
☐ **Full Time** ☐ **Student**
☐ **Part Time** ☐ **Unemployed**
☐ **Retired***(date)*_____
☐ **Disabled**

Hand Dominance ☐ **Right Handed** ☐ **Left Handed** ☐ **Ambidextrous (Both)**

Tobacco Use:

(Please indicate which best describes your habits)

☐ **Currently every day smoker** (at least smoked 100 cigarettes in a lifetime and still smokes either regularly or periodically)
☐ **Current some day smoker** (at least smoked 100 cigarettes and still smokes either regularly or periodically)
☐ **Former Smoker** (has smoked at least 100 cigarettes in a lifetime but currently does not smoke)
☐ **Never Smoked** (has not smoked 100 or more cigarettes in a lifetime)
☐ **Smoker** (current status unknown but is known to have smoked at least 100 cigarettes in a lifetime)
☐ **Unknown if ever smoked**

Alcohol Use:
(Please indicate which best describes your habits)
- ☐ Current Alcohol Use
- ☐ Occasional Alcohol Use
- ☐ Rare Alcohol Use
- ☐ Former Alcohol Use

Drug Use:
- ☐ No Illicit Drug Use
- ☐ Positive Illicit Drug Use

Drug Type:_____
Addiction
- ☐ Regular Use
- ☐ Sporadic Use
- ☐ Former Drug Use

Exercise:
- ☐ No Exercise
- ☐ Rarely Exercise
- ☐ Regular Exercise
- ☐ Sporadic Exercise
- ☐ Formerly Exercised

Review of Systems
(Please indicate if you currently are experiencing any of the following)

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Sweats
- ☐ Weight Changes

Eyes
- ☐ Vision Impairment
- ☐ Double Vision
- ☐ Light Sensitivity

Ears/Nose/Throat/Mouth
- ☐ Impaired Hearing
- ☐ Dizziness
- ☐ Nose Bleeds
- ☐ Runny Nose
- ☐ Frequent Sneezing
- ☐ Cold Sores
- ☐ Snoring

Cardiovascular
- ☐ Chest Pain
- ☐ Fainting
- ☐ Leg Swelling
- ☐ Ankle Swelling
- ☐ Exercise Intolerance
- ☐ Vein Problems

Respiratory
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing

Gastrointestinal (GI)
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Reflux
- ☐ Incontinence of Bowel
- ☐ Bowel Changes:
  Describe_____

Genitourinary (GU)
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Incontinence of Urine
- ☐ Blood in Urine
- ☐ Nighttime Urination

Musculoskeletal
- ☐ Muscle Cramps
- ☐ Stiffness
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness

Skin
- ☐ Change in Color
- ☐ Dryness
- ☐ Hives
- ☐ Itchy Skin
- ☐ Mole Changes
- ☐ Rash

Neurologic
- ☐ Blackouts
- ☐ Fainting
- ☐ Headache
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors
- ☐ Speech Seizure
- ☐ Speech Change
- ☐ Memory Loss
- ☐ Weakness

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Pattern Disturbance

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Weight Gain
- ☐ Weight Loss

Blood Lymph
- ☐ Easy Bleeding
- ☐ Excessive Bleeding
- ☐ Enlarged Lymph
- ☐ Easy Bruising
- ☐ Excessive Bruising

Allergies
- ☐ Environmental Allergies
- ☐ Frequent Infections

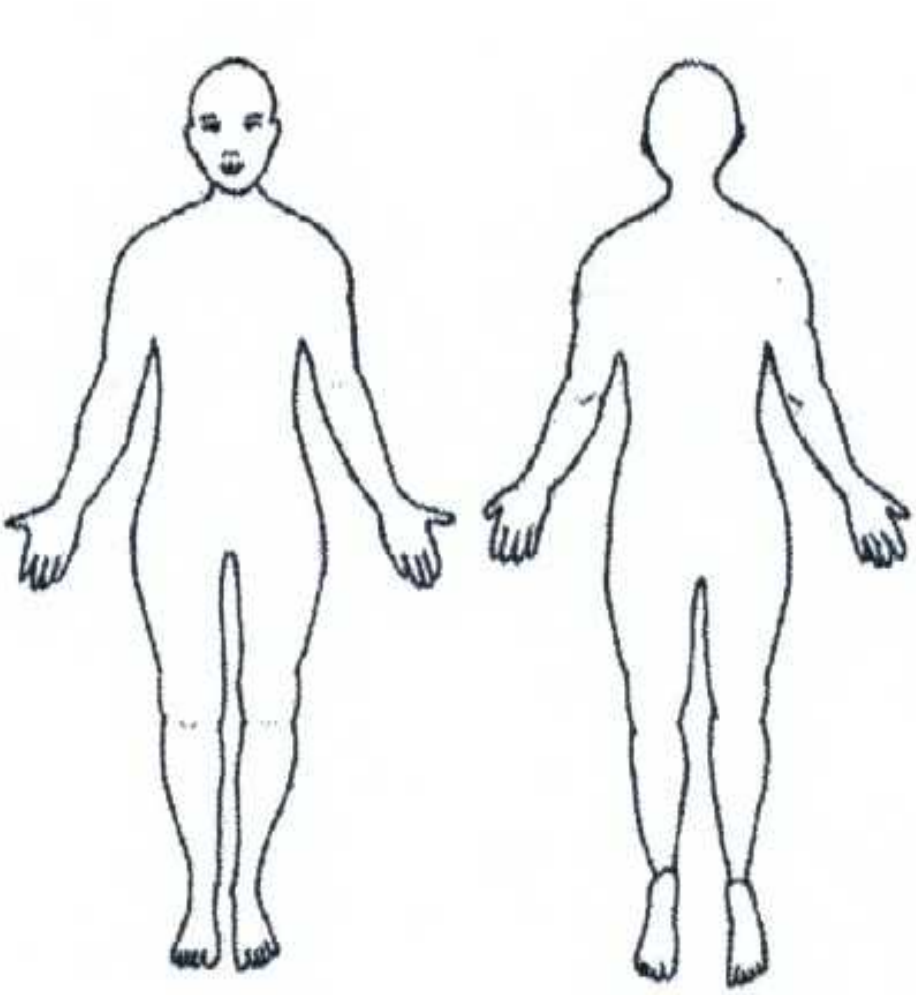
Description of Current Problem/Illness

Location of Problem (please indicate by checking most accurate descriptions)

Upper Extremity				Lower Extremity				
☐ Upper Arm	R	L	B	☐ Hip	R	L	B	
☐ Shoulder	R	L	B	☐ Thigh	R	L	B	☐ Head
☐ Clavicle	R	L	B	☐ Knee	R	L	B	
☐ Elbow	R	L	B	☐ Lower Leg	R	L	B	☐ Neck
☐ Forearm	R	L	B	☐ Ankle	R	L	B	
☐ Wrist	R	L	B	☐ Foot	R	L	B	☐ Pelvis
☐ Hand	R	L	B	☐ Great Toe	R	L	B	
☐ Index Finger	R	L	B	☐ 2nd Toe	R	L	B	☐ Spine
☐ Middle Finger	R	L	B	☐ 3rd Toe	R	L	B	
☐ Ring Finger	R	L	B	☐ 4th Toe	R	L	B	
☐ Small Finger	R	L	B	☐ 5th Toe	R	L	B	
☐ Thumb	R	L	B					

Location of Pain

Please indicate on drawing below where the pain/injury is located on your body



Chief Complaint

Please describe your symptoms

☐ Pain ☐ Numbness
☐ Tingling ☐ Other_____

What is the date of injury?_____

If you do not have a date of injury, please describe how your pain or complaint occurred:_____

_____

Mechanism of Injury

Please describe how this injury occurred

_____

Have you previously been treated for this injury/problem? ☐ Yes ☐ No
If **yes**, when?_____

If **yes**, who treated you? ☐ Primary Care Physician ☐ Specialist_____
☐ Hospital ☐ Urgent Care

Pain Duration

How long has this been a problem for you?

☐ Started Today
☐ Since Last Night
☐ Started Yesterday
☐ For a While
Days_____
Weeks_____
Months_____
Years_____
☐ Unknown

Pain Quality

☐ No Pain
☐ Burning
☐ Sharp
☐ Sore
☐ Stabbing
☐ Throbbing

Pain Severity

Indicate Current Pain Level

☐ 1 (None) ☐ 6
☐ 2 ☐ 7
☐ 3 ☐ 8
☐ 4 ☐ 9 (Severe)
☐ 5 (Moderate) ☐ 10

Pain Timing

☐ Continuous
☐ Intermittent
☐ Occasional
☐ Worse at night
☐ Worse with activity

Aggravates your pain

☐ Activity
☐ Bending
☐ Moving
☐ Sitting
☐ Standing

Alleviates your pain

☐ Antibiotics ☐ Immobilization
☐ Anti-Inflammatories ☐ Narcotics
☐ Assistive Device ☐ Physical Therapy
☐ Heat ☐ Rest
☐ Home Exercise ☐ Steroid Injections
☐ Ice

Associating Symptoms

☐ Catching ☐ Pain ☐ Popping ☐ Swelling
☐ Giving Out ☐ Shooting Pain ☐ Snapping ☐ Tingling
☐ Instability ☐ Pain at Night ☐ Spasms ☐ Weakness
☐ Numbness ☐ Pain While Sleeping ☐ Stiffness ☐ Other_____

Previous Testing

Have you had any previous testing/studies done for this injury/problem? ☐ Yes ☐ No

If **yes**, please indicate below and write the location and date of testing on the line next to the appropriate answer:

☐ Bone Scan_____

☐ EMG/NCS_____

☐ MRI/CAT SCAN_____

☐ X-Ray_____

Are You Currently Working?

☐ No/Disabled
☐ No/Retired
☐ No/Student
☐ Yes/Regular Duty
☐ Yes/Light Duty

Medications/Drug Allergies

Are you currently taking any medications? ☐ Yes ☐ No

If **yes**, please list below:

Name	Dosage	How Often

Are you allergic to any medications? ☐ Yes ☐ No
If **yes**, please list below:

Name of Medication	Type of Reaction	Name of Medication	Type of Reaction

Please indicate if you have any of the following **non-medication** allergies:

☐ Latex
☐ Tape/Band Aids
☐ Iodine
☐ Contrast Dye