AGILITY ORTHOPAEDICS

Joshua P. Nadaud, M.D. Jason D. Rabenold, M.D.

GENERAL PATIENT INFORMATION

Patient Name (print): _____ Birthdate: _____ Today's Date: _____

Address: _____ City: _____ State: _____

Phone: _____ Cell Phone: _____ E-mail: _____

Billing and Insurance

Primary insurance holder: ☐ Self ☐ Other If other, insurance holder's name: _____

Insurance holder's DOB: _____ Insurance holder's SS#: _____-_____-_____

Primary Insurance Company: _____

Policy Number/ID: _____ Group Number: _____

Secondary Insurance Company: _____ Phone: _____

Policy Number/ID: _____ Group # _____

Emergency Contact: _____ Relationship: _____

Emergency contact's phone: _____ Office/Cell: _____

Primary Doctor: _____ Phone: _____

Address: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

How were you referred to Agility Orthopaedics? _____

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Patient Name (print): _____ **Birthdate:** _____ **Date:** _____

Age: _____ Gender: ☐ F ☐ M Dominant Hand: ☐ R ☐ L Height: _____ Weight: _____

Who referred you to this office?

☐ Doctor _____ ☐ Self-referral ☐ Friend/Family Member ☐ Attorney _____

1. *(Chief Complaint) Main reason for visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other _____

2. *(Location) What body part is involved? (Check Below)

Neck ☐ and ☐ R arm radiates to ☐ L arm	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
Back ☐ and ☐ R leg radiates to ☐ L leg	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger ☐ R ☐ L	Hip ☐ R ☐ L	Ankle ☐ R ☐ L	Toe ☐ R ☐ L

3. *How long has problem been present? ____ Days ____ Weeks ____ Months ____ Years

4. Check the ONE box below that best describes **how your problem started**. Use the space to the right to further describe how your problem started.

☐ **NO INJURY** (onset was: ☐ Gradual or ☐ Sudden)
Why do you think it started?

☐ **INJURY** (from Accident or Sport **NOT** work or Auto)
Date _____ , Where and how did it happen?
What sport: _____ School: _____

☐ **INJURY AT WORK** Date: _____
From a ☐ lift ☐ twist ☐ bend ☐ pull ☐ reach

☐ **WORK RELATED (BUT NO INJURY)**
Date: _____ , How did job cause this problem?

☐ **AUTO ACCIDENT** Date: _____ How was car hit?

Answer and comments:

_____
_____
_____
_____
_____
_____
_____

Please check the box in each category that best describes your problem:

5. *Severity of pain? ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely severe
6. *Quality of pain? ☐ Sharp ☐ Dull Stabbing ☐ Throbbing ☐ Aching ☐ Burning
7. Timing of pain? ☐ Constant ☐ Comes and goes Does pain wake you from sleep? ☐ Y ☐ N
8. Do you have? ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of bowel/bladder
9. Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged
10. What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ❑ Sitting ☐ Coughing ☐ Sneezing
11. What makes it better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _____
12. What medications have you taken for this problem? _____
13. Which treatment have you tried? ☐ Injection ☐ Brace ☐ Therapy ☐ Cane/crutch
14. Were you seen in an Emergency Room for this problem? ☐ N ☐ Y
If yes, which ER and date?_____
15. What tests have you had? ☐ X-rays ☐ MRI ☐ CAT scan ☐ Bone scan ☐ Nerve test (EMG/NCV)
16. Have you already had surgery for this problem? ☐ N ☐ Y Surgeon's name: _____ Date: _____

PAST MEDICAL HISTORY

(answering these questions helps the doctor effectively treat your current orthopaedic problem)

1. Do you take any prescription or non-prescription MEDICATIONS? ☐ No ☐ Yes (list below)

Medication Dose Medication Dose

_____

_____

_____

2. Are you ALLERGIC to any medications? ☐ No ☐ Yes List: _____

3. List other products that you are Allergic to (e.g. eggs, latex, iodine, etc.): _____

4. Have you ever had SURGERY? ☐ No ☐ Yes (Please List details below)

Surgery Date Surgery Date

_____

_____

_____

5. Did you have any adverse reaction to anesthesia? ☐ No ☐ Yes (Please describe) _____

6. Do you have any MEDICAL PROBLEMS? ☐ No ☐ Yes (Please circle below)

Diabetes	High blood pressure	Heart problems	Blood clots	Asthma
Bronchitis	Emphysema	Kidney problems	Hepatitis	Thyroid Disease
Ulcers Seizures	Stroke	Tuberculosis	Rheumatoid	Arthritis

Cancer: _____ Other: _____

REVIEW OF SYSTEMS

1. Have you ever had a prior problem with the same orthopaedic condition you are here for today?

☐ N ☐ Y Do you have OTHER JOINTS with ☐ morning stiffness, ☐ swelling or ☐ pain?

(Please check any that apply to you or mark NONE) NONE

2. ☐ Heartburn	☐ Nausea	☐ Vomiting	☐ Blood in stool	☐
	☐ Stomach pain with anti-inflammatory pills			☐
3. ☐ Excessive thirst	☐ Heat or cold intolerance			☐
4. ☐ Weight loss	☐ Fever		☐ Loss of appetite	☐
5. ☐ Blurred vision	☐ Double vision		☐ Vision loss	☐
6. ☐ Hearing loss	☐ Hoarseness		☐ Trouble swallowing	☐
7. ☐ Chest pain	☐ Palpitations			☐
8. ☐ Chronic cough	☐ Shortness of breath			☐
9. ☐ Painful urination	☐ Blood in Urine			☐
10. ☐ Rash Skin	☐ Ulcers	☐ Lumps	☐ Psoriasis	☐
11. ☐ Headaches	☐ Dizziness			☐
12. ☐ Depression	☐ Drug/Alcohol Addiction		☐ Sleep disorder	☐
13. ☐ Easy bleeding	☐ Easy bruising		☐ Anemia	☐

FAMILY HISTORY

Has any direct relative had any of the following? ☐ No ☐ Yes (please mark all that apply)

☐ Rheumatoid arthritis ☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ Reaction to anesthesia

Same Orthopaedic condition you are being seen for today? ☐ No ☐ Yes

SOCIAL HISTORY

Do you use tobacco? ☐ No ☐ Yes Packs per day? _____

Alcohol use? ☐ No ☐ Yes How often? ☐ Daily ☐ Other _____

Marital history: ☐ Married ☐ Single ☐ Divorced ☐ Windowed

Occupation:_____ Employer_____ ☐ Student

Are you currently working? ☐ No ☐ Yes If NO, how long have you been off work? _____

Patient Signature _____ Date _____

For Office Use Only

Reviewed by M.D. _____ Date _____