



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? _____

AGILITY **ORTHOPAEDICS**

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

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 <input type="checkbox"/> and <input type="checkbox"/> R arm radiates to <input type="checkbox"/> L arm	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
Back <input type="checkbox"/> and <input type="checkbox"/> R leg radiates to <input type="checkbox"/> L leg	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> 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?

Answer and comments:

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?

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

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 _____