Orlin & Cohen Medical Specialists Group

Patient Label

Sports Medicine, Joint Replacement, Arthroscopy & Reconstructive Surgery, Foot & Ankle Surgery, Knee & Shoulder Reconstruction, Spinal Surgery & Pain Management, Hand & Elbow Surgery, Trauma

NEW PATIENT INFORMATION FORM/PAIN MANAGEMENT

LAST ______ M.I. ______ FIRST ______

STREET # & NAME OR P.O. BOX ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ WORK PHONE ______ CELL PHONE ______

SS # ______ DOB ______ SEX ______ E-MAIL ______

NAME OF SPOUSE/PARTNER/GUARDIAN (EMERGENCY CONTACT) ______ PHONE ______

REFERRING PHYSICIAN NAME ______ ADDRESS ______ PHONE ______

PRIMARY CARE PHYSICIAN NAME ______ ADDRESS ______ PHONE ______

INSURANCE: PRIMARY ______ SECONDARY ______

INSURED ______ EMPLOYER ______ INSURED DOB ______

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports / Light Duty / Not working due to the Injury

Does this visit involve a workman's Compensation issue? YES / NO   Hand Dominance: ❑ LEFT ❑ RIGHT

Was your injury reported to your employer ❑ Yes ❑ No

Body Part Injured: ______________________________ Cause: Sports/Work/Auto/Other

Date of Injury/Accident/Onset:______________________ Time & Place ______________________

How did the Injury Occur? ______________________________

Where is your pain today? ❑ Lower Back ❑ Neck ❑ Right Leg ❑ Left Leg ❑ Right Arm ❑ Left Arm ❑ Mid-Back ❑ Upper Back ❑ Buttock ❑ Head ❑ Other__________________

Does your pain radiate YES / NO? If yes, where______________________________

Quality: What type of pain do you have? ❑ Burning ❑ Diffuse ❑ Dull/Aching ❑ Localized ❑ Radiating ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Throbbing ❑ Tightness ❑ Tingling ❑ Squeezing ❑ Other_______

Does the pain affect your activity in these different areas? *Check all that apply* ❑ Household Chores ❑ Leisure ❑ Work ❑Sleep ❑ Sexual Activity ❑ Social Interactions ❑ Other______________

Pain at Rest: 0 –10______________________ Pain at Activity: 0 –10______________________

Is your pain ❑ Constant ❑ Intermittent ❑ Frequent ❑ Occasional

Does anything make your pain better? *Check all that apply* ❑ Rest ❑ Meds ❑ Bending/Leaning Forward ❑ Extending back ❑ Ice ❑ Heat ❑ Sitting ❑ Standing ❑ Walking / Activity ❑ Massage ❑ Physical Therapy ❑ Injection Therapy ❑ Nothing helps ❑ Other_________________

Does anything make your pain worse? *Check all that apply* ❑ Sitting ❑ Standing ❑ Walking ❑ Bending Forward ❑ Extending back ❑ Lifting ❑ Exercise ❑ Stairs ❑ Lying in Bed ❑ Coughing ❑ Physical Therapy ❑ Other_______

Have you had any new tests or imaging studies for this problem? YES / NO

If yes, list facility, type & date: ______________________________

Have you had physical therapy for this problem? YES / NO If yes Date(s):______________________

If you were/are unable to work/play, list dates of disability:__________________ to __________________

Do you need support to help you ambulate? YES / NO

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Past Medical History: (PHX) *Please list none if the question does not apply.* Height__________ Weight____________

Medical Problems:____

____

Previous Hospitalizations & Surgical Procedures: (Provide Dates)______________________________________

____

Please list all allergies (drug, food, environmental):____

____

Current Medications: (Include Doses and Frequency) ____

____

List any side effects to medications: ____

____

Family Medical History: (Include Medical Illness Affecting Patient's Immediate Family) ____________________

____

Social History: (Check Boxes and Fill Blanks)

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other:__________________

Alcohol Use: ❑ Occasional ❑ Daily ❑ Heavy ❑ None

Tobacco Use: ❑ Yes ❑ No (Type:___________________Packs Per Day________Years Used:________)

Recreational Drug Use: ❑ Yes ❑ No (Types):_____________________________________ _________)

REVIEW OF SYSTEMS: (Check All That Apply)

GENERAL
- ❑ Weight Change
- ❑ Fever or Chills
- ❑ AIDS/HIV
- ❑ Night Sweats
- ❑ Bleeding
- ❑ Lumps or Masses
- ❑ Dizziness or Fainting
- ❑ Diabetes Mellitus
- ❑ Thyroid Problem
- ❑ Cancer

SKIN
- ❑ Itching or Rash
- ❑ Wound Discharge

GASTROINTESTINAL
- ❑ Difficulty Swallowing
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Reflux
- ❑ Ulcer

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Thrombophlebitis/DVT/PE

GENITOURINARY
- ❑ Urinary Infections
- ❑ Incontinence
- ❑ Urinary Frequency
- ❑ Venereal Disease
- ❑ Menopause

NEUROLOGIC
- ❑ Seizures
- ❑ Numbness
- ❑ Weakness

EAR-EYES-NOSE-THROAT
- ❑ Visual Change
- ❑ Hearing Change
- ❑ Tinnitus
- ❑ Bleeding Gums

RESPIRATORY
- ❑ Cough/Sputum
- ❑ Tuberculosis
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema

MUSCULOSKELETAL
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Neck Pain

PSYCHOLOGICAL
- ❑ Depression
- ❑ Bipolar
- ❑ ADD/ADHD
- ❑ Other

❑ All Systems Reviewed & Negative

Pharmacy Information Sheet

We can send your prescriptions directly to your pharmacy so that there is less waiting time for you. If you know your pharmacy, please complete the below form. Please be aware that the easiest way for us to find your pharmacy is to know the zip code.

Your Name:		Date of Birth:
Pharmacy Name:		
Address:		
City:	State:	Zip:
Pharmacy Phone #:	Pharmacy Fax:	

______________________________ Patient/Guardian Signature

__________ Date

______________________________ Physician's Signature

__________ Date