



Orthopedic SPECIALTY INSTITUTE

Today's Date: _____

Patient's Name: _____ Birth Date: _____

Guarantor Info if under 18: _____

SS #: _____ Age: _____ Gender: M / F Email: _____

Address: _____

Phone: _____

(home)

(work)

(cell)

Marital Status: Single Married Divorced/Separated Widowed

Preferred Language: English Other: _____

Race: American Indian Asian Black/African American Japanese White Other: _____ Declined

Ethnicity: Central American Hispanic or Latino/Spanish Not Hispanic or Latino Other: _____ Declined

Employer Name & Address: _____

Primary Insurance Coverage:

(Name of Carrier) (Policy Number) (Group Number)

(Subscribers Name & Relationship to patient) (Subscriber DOB) (Insurance Phone)

Secondary Insurance Coverage:

(Name of Carrier) (Policy Number) (Group Number)

(Subscribers Name & Relationship to patient) (Subscriber DOB) (Insurance Phone)

1) How did you hear about us or who sent you to see us?

Name _____ Phone _____

2) Who is your Primary Care Physician?

Name _____ Phone _____

City, State, Zip _____

What Pharmacy do you use?

Name _____ Phone _____

City, State & Zip _____

Are you currently taking any narcotics? ____ Yes ____ No What? _____ How long? _____

I agree that The Lyman Knee Clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature of Patient or Patient's Representative: _____

3) Please list all medications you currently use with dosage and frequency:

4) Do you have any allergies? Yes No

If yes, please list the medication and the reaction; _____

5) Are you allergic to Latex or Tape? Yes No

6) Have you ever had MRSA? Yes No

7) Are you currently or have you ever had problems with the following:

	Y	N		Y	N
No Past Medical Problems Reported			Liver Disease		
Anxiety Disorder			Low Back Pain		
Arthritis: What Kind: _____			Neck Pain		
Asthma			Mid Back Pain		
Bleeding Disorder			Radiculopathy – Upper		
Blood Clots (Deep Vein Thrombosis)			Radiculopathy – Lower		
Cancer: What Kind: _____			Organ Transplant		
CHF			Osteopenia		
Claustrophobic			Osteoporosis		
Coronary Artery Disease			Other Lung Disease		
COPD			Poliomyelitis		
Diabetes Type I			Peripheral Vascular Problem		
Diabetes Type II			Pulmonary Embolism		
Dialysis			Reflux Disease		
Diverticulitis			Rheumatoid Arthritis		
Fibromyalgia			Sciatica		
Gout			Stroke		
Pacemaker			Tuberculosis (TB)		
Heart Arrhythmia			Ulcers		
Heart Attach (MI)			Urinary Tract Infection		
Heart Murmur			Other:		
Hiatal Hernia			Problems with Anesthesia		
HIV or AIDS			Hepatitis		
Hypertension					
Hypercholesterolemia					
Hyperthyroidism					
IBS (Irritable Bowel Syndrome)					
Kidney Disease					
Kidney Stones					
Leg/Foot Ulcers					

8) Please list all past surgeries and hospitalizations:

Surgery/Hospitalization	Date	Physician

9) Have you ever had problems with general anesthesia? YES NO

10) Do you drink alcohol? YES NO If yes, how much per week? _____

11) Do you smoke? YES NO If yes, how much per week? _____
If yes, how long have you smoked? _____

12) Do you:

	YES	NO	
Have children	<input type="checkbox"/>	<input type="checkbox"/>	How many _____
Live alone	<input type="checkbox"/>	<input type="checkbox"/>	If no, with whom _____
Use a special diet	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Use recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Exercise regularly	<input type="checkbox"/>	<input type="checkbox"/>	How often _____

13) Sports/Hobbies: _____

14) Family History

Member	If Alive, Age & Health Status	If Deceased, Age at Time of Death & Cause
Father	_____	_____
Mother	_____	_____
Sibling 1	_____	_____
Sibling 2	_____	_____
Sibling 3	_____	_____

Current Vitals:

Height: _____ Weight: _____

15) Chief Complaint/Current Illness:

(Circle one below)

- a) Is your problem in the: Right Left
- b) Hand Wrist Forearm Elbow Shoulder Foot Ankle Lower leg Upper leg Hip Pelvis
 Other _____
- b) Describe your chief complaint? _____
- c) How long have you had this problem? _____
- d) Was this a result of an injury? Yes No If Yes, what was the Date of Injury? _____

16) Work-Related Injury:

- a) Job title: _____
 - b) How long have you worked for this employer? _____
 - c) Date of injury: _____
 - d) Are you: off work modified duty full duty
 - e) If you are not working full duty, what date did you last do so: _____
- Please describe how it happened: _____

17) If PAIN is one of your complaints, please complete the following questions.

- a) Rate the average intensity of your pain/discomfort. (0=no pain, 10=severe pain)
0 1 2 3 4 5 6 7 8 9 10
- b) Describe your Pain: Intermittent Constant
 Dull Sharp Throbbing
 Tight Burning Tingling

18) Timing

- 1) Is your pain worse at any particular time of the day? Morning Evening Night
2) Does your hand/wrist allow you to sleep comfortably? Yes No

19) Do you ever have any of these additional symptoms?

	YES	NO	If yes, describe
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

20) Have you tried any of the below? Relief of Symptoms?

	YES	NO	
Medication	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
Therapy	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how long did you attend? _____ When was your last session? _____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	If yes, location & medication? _____
Other	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____

_____ I acknowledge that I have received the Notice of Privacy Practices of OSI which explains its legal duties and privacy practices with respect to my protected health information.

By signing below, I agree that all the information provided is true to the best of my knowledge. I also hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for the noncovered services. I also authorize the physician to release any information required to process this claim.

Patient Signature _____ **Date** _____

I have reviewed the above information in detail with the patient.

Physician Signature _____ **Date** _____