SCHEINBERG ORTHOPEDIC GROUP

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Welcome to our clinic! Prior to being seen, we ask you to fill out these forms as accurately as possible. While some of the questions may not seem relevant to your problem, they give us an idea about your medical status, the circumstances relating to your problem and your overall situation. Please sign and date the bottom of the last page. Thank you.

Last Name ______ First Name ______ DOB ______

Address ______ City ______ Zip ______

Home Phone # ______ Work Phone # ______ Soc. Sec # ______ Email Address ______

Male ______ Female ______ Weight ______lbs. Height ______

MARITAL Status: Single__ Married__ If married, please provide spouses name: ______

Language: ______ Spanish ______English Other (Specify) ______

Do you have an interpreter? __No __Yes Name: ______Phone #:______

Race/Ethnic Group: ___Caucasian ____ African-American ____Hispanic ____European ____Asian ____American ____ American-Indian ____Hawaiian other ______

Were you referred to our office by another physician or by an attorney: _____Yes _____No

If so, what is the Physician's or Attorney name and contact information:
Name______ Address ______

______Phone #: ______

Emergency Contact: Please indicate if you authorize the following designated person's to have access to your medical information and to be contacted in case we are unable to reach you.

[] ______ ______ ______
Name relationship to you phone number

[] ______ ______ ______
Name relationship to you phone number

Primary care physician (doctor who over see's your general health or specialist)

Name ______ Specialty ______ Phone number ______

Name ______ Specialty ______ Phone number ______

History of Present Illness

Is this a work related injury? _____Yes _____No

Date of Injury: ______ Claim #: ______

Name of the Insurance: ______ Phone # ______

Address: ______

Name of the Employer at time of accident: ______

Address: ______

Phone: ______ Job: ______

Description of the job: ______

Briefly describe how injury occurred: ______

Does anything help with easing the pain? ____ No ___ Yes If yes, please give example:

Please check any treatments that you have tried below indicate the date of service, for what body part, the quantity/duration and the name of provider/facility:

- Imaging Studies (MRI's , EMG's X-ray's)______
- Physical Therapy/Exercise ______
- ______
- Chiropractic treatment ______
  Steroid Injections/pain management ______
- Cast ______
- Walker/Cane______
- Off the shelf/Custom made brace ______
- Other______
- Off the shelf/Custom made brace ______
- Other______

Which problem/symptoms (body parts) are you seeing the doctor for today? (Indicate left or right)

Body Part	Pain Level scale 0-10 (0 being no pain and 10 being very painful)		How would you describe your pain? (Burning, aching, throbbing, tingling etc.)
	Right	Left	
Head			
Neck			
Shoulder			
Arm			
Elbow			
Wrist			
Hand			
Finger's			
Chest			
Back			
Abdomen			
Hip			
Leg			
Knee			
Ankle			
Foot			
Toe's			
Other			

List all major illnesses (Diabetes, high blood pressure, heart attack, etc.):

____

____

____

List any Medications you currently take, doses, and how often (Rx and over the counter):

____

____

____

Do you have allergies to any medications? _____ **NO** _____ **YES** Please List: ____________________

____

Surgical History

Have you ever had general anesthesia? ___Yes ___No
If yes, did you have any problems related to the anesthesia? ___Yes ___ No
Please describe any problems:______________________________

Please list any surgical procedures you have had performed and date of procedure:

____________________ ____________________

____________________ ____________________

FAMILY HISTORY (MOTHER, FATHER, GRANDPARENT, SIBLING)

Has any member of your family had these diseases? (Circle) ______**YES** ______**NO** ______**UNKNOWN**

DIABETES__________________, HYPERTENSION____________________, HEART DISEASE_________________,

STROKE__________________, CANCER________________________, THYROID DISEASE_________________,

ARTHRITIS____________________ OTHER FAMILY DISEASES____

SOCIAL HISTORY

Do you drink alcoholic beverages? _____**YES** _____**NO** IF YES, HOW MUCH? ___________________________

Do you use any form of tobacco? ___**YES** ___**NO** IF cigarettes, How many per-day? _________________

Are you Involve in any sports? ___**Yes** ___**No** if so, list all. ______________________________

Do you use recreational drugs? ___**Yes** ___**No** please specify: ____________________________

<u>Do you currently have any problems in the following areas? If YES, please provide additional information.</u>

	Yes	No	Details/ Dates
GENERAL /Constitutional. Fever, heat stroke, weight loss, weight gain, usually tired			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth etc.)			
RESPIRATORY Congestion, wheezing, short of breath, etc.			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
GASTROINTESTINAL stomach upset, diarrhea, constipation, hernia, ulcer, etc.			
GENITAL, KIDNEY, BLADDER painful or frequent urination, impotence, yellow jaundice,			
FEMALES are you pregnant? Nursing?			
ENDOCRINE diabetes, hypothyroid, etc.			
NEUROLOGICAL numbness, headache, seizures, paralysis, etc.			
PSYCHIATRIC anxiety, depression, insomnia, etc.			
SKIN pimples, warts, growths, rash, etc.			
MUSCLE, BONES JOINTS join pain, stiffness, swelling, cramps, arthritis, etc.			
BLOOD/LIMPH bleeding, high cholesterol, anemia, problems related to blood transfusion, etc.			
ALLERGIC/ IMMUNOLOGIC sneezing, swelling, redness, itching, hives, lupus, etc.			

I authorize release of any records and billing to my attorney or insurance company. I authorize payments from my insurance company to be paid directly to Richard Sheinberg M.D. I permit a copy of this authorization to be used in place of the original.

______________________________________ ____________________

Patient Signature *Date*