

Total Orthopaedic Care Demographic Sheet

Date:

Please Print Below

Patient's Last Name: First:

Home Address:

City, State, Zip:

Date of Birth: Marital Status:

Home Phone: Social Security: Language:

Cell Phone: Email:

Emergency Contact Name: Contact Number:

Pharmacy Name: Pharmacy Number:

Primary Care Physician:

Primary Insurance Name: Policy Number:

Insured Name: Relationship:

Insured's Date of Birth: Insured's Sex: M F

Secondary Insurance Name: Policy Number:

Insured Name: Relationship:

Insured's Date of Birth: Insured's Sex: M F

Are you covered by any other insurance do to spouse, work, or alternative coverage? Y N

Auto Accident	Attorney
Were you the? <input type="checkbox"/> Driver <input type="checkbox"/> Passenger (Front seat) <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger (Back Seat)	Do you have an attorney as a result of this injury? <input type="checkbox"/> Y <input type="checkbox"/> N
Impact Direction? <input type="checkbox"/> Front End <input type="checkbox"/> Rear End <input type="checkbox"/> Passenger Side <input type="checkbox"/> Driver Side	Name of Attorney: <input type="text"/>
Were you wearing a seatbelt? <input type="checkbox"/> Y <input type="checkbox"/> N	Address: <input type="text"/>
Did you hit your head on the: <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield	Phone: <input type="text"/>
Did you hit the Steering Wheel? <input type="checkbox"/> Y <input type="checkbox"/> N	Fax: <input type="text"/>
Did you Lose Consciousness? <input type="checkbox"/> Y <input type="checkbox"/> N	
Did the Airbag Deploy? <input type="checkbox"/> Y <input type="checkbox"/> N	
List other areas of impact: <input type="text"/>	

I hereby consent to and authorize a physician and/or health care professional of T.O.C. to perform a physical examination, diagnostic procedure, and to prescribe a therapeutic regimen. I hereby authorize the physicians of T.O.C. to release any information including diagnosis acquired in the course of my exam to any health care facilities, physicians, insurance carriers, or collection agencies.

I hereby authorize my insurance carrier to pay directly to T.O.C. the medical benefits otherwise payable to me for their services, but not exceed the charges of those services.

I hereby irrevocably assign to T.O.C. any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the Florida statues for any service and/or charges provided by T.O.C.

The staff at T.O.C. is authorized to call me at the above listed numbers. If I am not available, they are permitted to leave a message with whomever answers or an answering machine / voice mail. I further understand that I am fully responsible for service provide that are not covered by my insurance.

Reason for Visit



Patient's Name:

Age: Height: Weight Sex: M F Right / Left Handed

Occupation: Patient's Employer: Work Phone:

What **Orthopaedic** problems are you having today?

How long have you had this problem?

Have you ever had pain, discomfort, or similar symptoms in this area before? Y N

Explain:

Was this caused by an injury? Y N Injury Date:

Is this Injury **Work Related** Y N Is this related to an **auto accident** Y N

If caused by injury, where did injury occur:

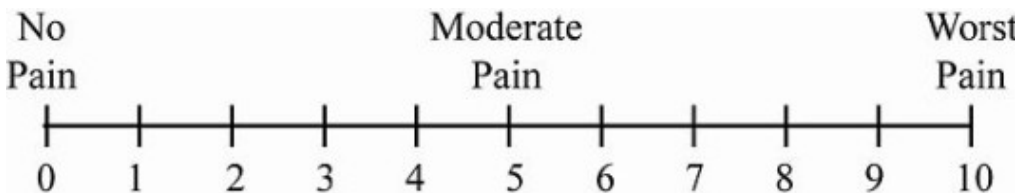
How did the injury occur?

When you first noticed this problem or pain, what were you doing?

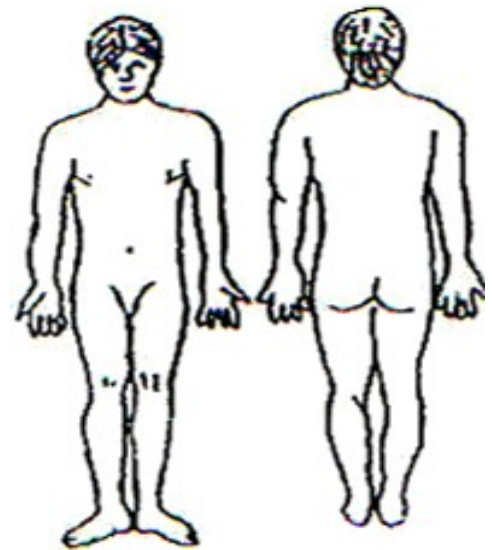
How were you referred to our office?

Pcp (name)	Hospital/ER (name)	Urgent Care (name)
Insurance Directory (name)	Work Comp (name)	Other (name)

On a scale of one to ten, how severe is your pain?



Please Mark Problem Areas



Right Left Left Right

Please describe your pain:

<input type="checkbox"/> Aching, like a toothache	<input type="checkbox"/> Radiating or spreading
<input type="checkbox"/> Burning, hot or on fire	<input type="checkbox"/> Sensitive, raw
<input type="checkbox"/> Cold, like ice, or freezing	<input type="checkbox"/> Sharp, like a knife, spike, or piercing
<input type="checkbox"/> Cramping, squeezing or tight	<input type="checkbox"/> Shooting or zapping
<input type="checkbox"/> Electrical, shocks, lightening, or sparking	<input type="checkbox"/> Tingling, pins and needles, prickling
<input type="checkbox"/> Heavy, pressure or weighed down	<input type="checkbox"/> Throbbing or pounding
<input type="checkbox"/> Itchy, like a mosquito bite	<input type="checkbox"/> Unpleasant, annoying, bothersome
<input type="checkbox"/> Numb or asleep	

How Consistent is your Pain? (Choose one)

Intermittent (Pain sometimes, but not all the time)	<input type="checkbox"/> Variable (Background pain all the time, but moments of severe pain)	<input type="checkbox"/> Stable (Constant pain all the time that doesn't change much)	<input type="checkbox"/>
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Have you had any treatment for *this* problem?

<input type="checkbox"/> Medication	<input type="checkbox"/> Cat Scan	<input type="checkbox"/> Other, Please list below:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Bone Scan	<input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> Injections	<input type="checkbox"/> Blood Work	<input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> X-rays	<input type="checkbox"/> Neurology Consult	<input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> MRI	<input type="checkbox"/> Pain Management Consult	<input style="width: 100%; height: 20px;" type="text"/>

Past Medical History

Patient's Name:

Date:

Please answer all questions below

Height: Weight Right / Left Handed

Do you take Coumadin / Plavix / Lovenox / Aggrenox or other blood thinners? Y N

Do you have a Pacemaker? Y N

Could you possibly be Pregnant? Y N Are you currently breastfeeding Y N

When did you have your first period? Date of last Period

Past Medical History		Past Surgical History		Date	Medication		Family History	
<input type="checkbox"/>	Abdominal / Inguinal Hernia	<input type="checkbox"/>	Appendectomy		Please List Medications Below		Father <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Cancer		<input type="text"/>			If deceased, Cause of Death <input type="text"/>
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Cataracts		<input type="text"/>			
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Gallbladder		<input type="text"/>		Mother <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	Gynecological		<input type="text"/>			If deceased, Cause of Death <input type="text"/>
<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Hand		<input type="text"/>			
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Heart		<input type="text"/>			
<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	Hysterectomy		<input type="text"/>			
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Joint Replacement		<input type="text"/>		Sibling <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Neck/Spine		<input type="text"/>			If deceased, Cause of Death <input type="text"/>
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Tubes (Ears)		<input type="text"/>			
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	None		<input type="text"/>			
<input type="checkbox"/>	HIV				<input type="text"/>		Social History	
<input type="checkbox"/>	Hiatal Hernia		Have you had a recent		<input type="text"/>		Tobacco Use <input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Bone Density Exam		Have you had any Anesthesia Problems?		Packs per day? <input type="text"/>	
<input type="checkbox"/>	Inflammatory Bowel Syndrome (IBS)	<input type="checkbox"/>	Colonoscopy		<input type="checkbox"/> Y <input type="checkbox"/> N		Alcohol Use <input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Gynecological Visit		<input type="text"/>		Drinks Per day? <input type="text"/>	
<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Mammogram		<input type="text"/>		History of Drug Use <input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Prostate Exam		<input type="text"/>			V3-19-12
<input type="checkbox"/>	Neurological Disorder				<input type="text"/>		Physician Notes:	
<input type="checkbox"/>	Osteoporosis		Allergies		<input type="text"/>			
<input type="checkbox"/>	Psychological	<input type="checkbox"/>	No Known Allergies		<input type="text"/>			
<input type="checkbox"/>	Reflux Disease	<input type="checkbox"/>	Anti-inflammatories		<input type="text"/>			
<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	Aspirin		<input type="text"/>			
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Dyes		<input type="text"/>			
<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Iodine		<input type="text"/>			
<input type="checkbox"/>	Urinary Disease	<input type="checkbox"/>	Latex		<input type="text"/>			
<input type="checkbox"/>	TB	<input type="checkbox"/>	Penicillin		<input type="text"/>			
<input type="checkbox"/>	Other Please list below	<input type="checkbox"/>	Sulfa/Sulfur		<input type="text"/>			
		<input type="checkbox"/>	Other Please list below		<input type="text"/>			
					<input type="text"/>			
					<input type="text"/>			
<input type="checkbox"/>	None of the Above				<input type="text"/>			

Patient's Name: Date:

Do you have or have you had any of these symptoms in the last two weeks?

Symptoms	Yes	No	Explain	Symptoms	Yes	No	Explain
Constitutional				Integumentary			
Fever	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Skin Rash	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Chills	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Boils	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Headaches	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Persistent Itch	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Eyes				Musculoskeletal			
Blurred Vision	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Joint pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Double Vision	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Neck Pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Eye Pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Back Pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Allergic/Immunologic				Ear/Nose/Throat/Mouth			
Hay Fever	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Ear Infection	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Drug Allergies	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Sore Throat	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Sinus Problem	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Neurological				Genitourinary			
Tremors	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Urine Retention	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Dizzy Spells	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Painful Urination	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Numbness/tingling	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Urinary Frequency	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Endocrine				Respiratory			
Excessive thirst	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Wheezing	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Too hot / cold	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Frequent Cough	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Tired / sluggish	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Shortness of Breath	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Gastrointestinal				Hematologic/Lymphatic			
Abdominal pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Swollen Glands	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Nausea/ vomiting	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Blood Clotting Problem	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Indigestion/heartburn	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Psychological			
Cardiovascular				Are you under the care of a mental health professional?	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Chest Pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Do you feel depressed?	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Varicose veins	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
High Blood Pressure	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>				
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>				

Patient's Signature _____ Physician Initials _____

Please dictate any positives and how the condition is being treated.
Review of Systems