ADVANCED ORTHOPEDICS NEW ENGLAND

Connecticut: Bloomfield • Enfield • Rocky Hill • Vernon
Massachusetts: Springfield

DEMOGRAPHICS INFORMATION FORM

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS

CITY & ZIP CODE

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED**

Please check the box for primary phone number:

☐ HOME PHONE	☐ WORK PHONE	☐ CELL PHONE

EMAIL

PRIMARY CARE DOCTOR

INSURANCE ID NUMBER

SUBSCRIBER NAME & DOB

EMPLOYMENT COMPANY/STATUS

PHARMACY NAME & TOWN

EMERGENCY CONTACT NAME	PHONE NUMBER	RELATION

WHERE DID YOU GET INJURED?

☐ HOME ☐ WORK ☐ MOTOR VEHICLE ACCIDENT ☐ N/A ☐ OTHER: _____

HOW DID YOU HEAR ABOUT US? _____

SIGNATURE: _____ **DATE:**_____

PATIENT HEALTH HISTORY

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Patient Name:_____DOB:___/___/___ **Treating Orthopedic Doctor:**_____

Chief Complaint (why are you here today?): _____

When did the symptoms begin?_____

How did incident occur? ☐ Motor vehicle accident ☐ At work ☐ At School ☐ Home ☐ other: _____

Injury mechanism: ☐ no injury mechanism ☐ direct blow ☐ fall ☐ twisting injury

Height:_____ **Weight:**_____ **Occupation:** _____

Allergies: ☐ No known Allergies _____

ALL current medications (including over the counter): ☐ Not taking any medications _____

_____

_____

PAST MEDICAL HISTORY	YES	NO	PAST MEDICAL HISTORY	YES	NO
Anemia			HIV/AIDS/Hepatitis		
Asthma			Hypo/Hyperthyroidism		
Blood Clot/DVT			Lyme Disease		
Cancer:			Osteoporosis/Osteopenia		
COPD			Peripheral Vascular Disease		
Diabetes Type I/Type II			Psoriasis		
Gout			Renal Failure/Kidney Disease		
Heart Attack/Angina			Rheumatoid Arthritis/Lupus		
Heart Disease/**Pacemaker**			Stroke		
High Blood Pressure			Tuberculosis		
History of Blood Transfusion			Ulcer/Acid Reflux/GERD		
History of Prednisone or Steroid Medication			Other:		

PAST SURGERIES	SURGEON	DATE

FAMILY HISTORY: Please check all that apply ☐ Family History Unknown ☐ Adopted

Relationship	Anesthesia Problems	Arthritis	Blood Clots	Cancer	Diabetes	Heart Disease	High Cholesterol	Hypertension	Rheumatologic Disease	Scoliosis
Mother										
Father										
Sister										
Brother										

ALCOHOL USE: ☐ Yes ☐ No - **Drinks/Week**_____ ☐ wine ☐ beer ☐ liquor **DRUG USE:** ☐ Yes ☐ No

TOBACCO USE	Cigarettes	Cigars	Pipe	Chew	Snuff	Smokeless Tobacco
NEVER						
START DATE						
QUIT DATE						
PACKS/DAY						

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NAME:_____ DOB:____/____/____

If first appointment or new injury, please start here and complete the rest of the form:

How did injury occur? ☐ HOME ☐ WORK ☐ AUTO ACCIDENT ☐ OTHER:_____

For Follow-Up appointments, start here: **Body Part:**_____ **RIGHT** **LEFT** **BILATERAL**

Pain quality:	none	aching		burning		cramping		shooting		stabbing	sharp
Pain Scale:	On average:	0	1	2	3	4	5	6	7	8	9	10
	At its worse:	0	1	2	3	4	5	6	7	8	9	10

Pain Severity:	none	mild	moderate	severe	
Pain frequency:	none	constant	intermittent		
Progression:	same	improving	worsening		
Symptoms:	none	inability to bear weight		loss of motion	loss of sensation
	numbness	tingling	swelling	radiating pain	muscle weakness

Other Symptoms: _____

Aggravated by:	nothing	movement	palpation	weight bearing	lifting
Prior Treatments:	nothing	elevation	heat	immobilization	home exercises
	rest	ice	bracing	cortisone injections	non-weight bearing

Other prior treatments: _____

Physical therapy: YES NO **Start Date:**_____ **For how many weeks:**_____

Improvement on prior treatments: no relief mild relief moderate relief significant relief

Have you taken any pain medications for your condition? (Prescription and/or over the counter)

Medication name:_____ Was it helpful? Yes No Moderate

REVIEW OF SYSTEMS (Please Circle all that apply)

Abdominal pain/discomfort	Abnormal Menstrual periods	Back Pain	Chest Pain
Chills	Constipation	Depression	Diarrhea
Double Vision	Easy Bruising	Environment Allergies	Fatigue
Fever	Glasses	Headaches	Incontinence
Joint Pain (Arthralgia)	Leg swelling/pain	Neck Pain	Neck Stiffness
Nervousness/Anxiety	Numbness	Rash	Shortness of Breath

None of the Above

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