PremierOrtho
BONE • SPINE • JOINT • PAIN
your life in motion
a division of premier healthcare

1 2 3 4 5
Dx:__________

John Hammerstein, MD
Brian Murphy, MD
Jeff Thomas, MD
Cheryl Pittsford, PA-C
www.mypremierortho.com
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Patient Contact Information

Please Print Legibly

Name ______________________________ Age _______ Date _____________

Date of Birth _________________ Social Security # ____________________________

Address ____

City, State, Zip Code ____

Home Phone ____________________ Work/Cell ______________________________

Race __________________________ Ethnicity ________________________________

Occupation ____

Employer Name ____

Employer Address __________________________________ Phone ________________

Referring Physician ____

Primary Care Physician ____

Emergency Contact/Relationship ____

Phone ____

Health Insurance Company **** Policy number is not needed if card has been copied ****

Primary ______________________________ Policy _____________________________

Secondary ____________________________ Policy _____________________________

Please present your insurance company card upon office visit. A photocopy must be made before services are rendered.

Payment Guarantor (If name on insurance card is not your own)

Name ____

Date of Birth ____

Social Security # ____

Patient Medical History

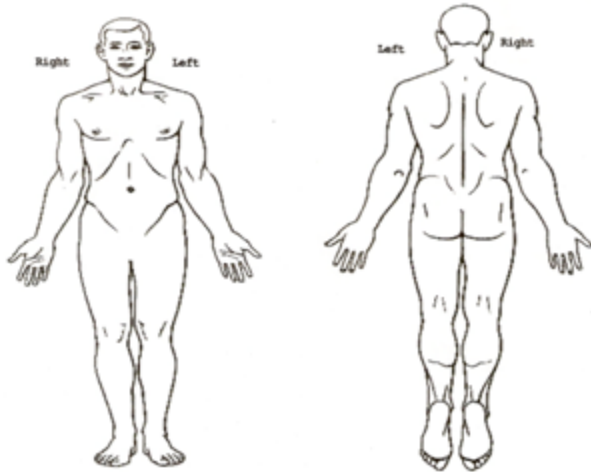
History of problem for which you are seeing us

Duration of symptoms ____

How did problem start? ☐No injury/event ☐At work (date________) ☐ Home/leisure.

Briefly describe events: ____

If you have pain or numbness: Mark **"X"** on the body part(s) with pain.
Mark **"O"** on body part(s) with numbness.



Pain Scale Please circle appropriate number: 1 = no pain, 10 = severe pain.

Typically, pain level is: 1-----2-----3----4----5----6----7----8----9----10

At its worst, my pain is: 1-----2-----3----4----5----6----7----8----9----10

At its best, my pain level is: 1-----2-----3----4----5----6----7----8----9----10

Character of pain:	☐ Burning	☐ Stabbing	☐ Deep ache
Frequency:	☐ Constant	☐ Intermittent	☐ Rare
Improvement? (since onset)	☐ Worsened	☐ Improved	☐ Stayed the same
Weakness:	☐ Yes	☐ No	If yes, which area? ________________
Incontinence? (urine or stool)	☐ Yes	☐ No	If yes, how often? _________________
Fevers/Chills?	☐ Yes	☐ No	If yes, how often? _________________

Diagnostic History

X-rays	☐ Yes	☐ No	Date/Location ______________________
MRI	☐ Yes	☐ No	Date/Location ______________________
CT scan	☐ Yes	☐ No	Date/Location ______________________
Bone scan	☐ Yes	☐ No	Date/Location ______________________
EMG	☐ Yes	☐ No	Date/Location ______________________
Other	☐ Yes	☐ No	Date/Location ______________________

Allergies ____

Medications	**Example:**	**Received:**	**Did it work?**
Anti-inflammatory	Naprosyn, Ibuprofen	Y – N	Y – N
Muscle relaxer	Soma, Flexeril, Skelaxin	Y – N	Y – N
Pain medication	Tylenol w/codeine, Vicodin, Darvocet, Percocet	Y – N	Y – N
Oral Steroid	Medrol Dose Pak, Prednisone	Y – N	Y – N
Nerve medication	Lyrica, Neurontin	Y – N	Y – N

Treatments	**Received:**	**Did it help?**
Physical therapy	Y – N	Y – N
Chiropractic care	Y – N	Y – N
Epidural injection	Y – N	Y – N

Consultations

Have you seen another spine care specialist for this problem? ☐Yes ☐No

If yes, Date________________ Name of Physician:_______________________

Recommendations/treatments: ____

Legal advice

Do you have an attorney regarding this injury/problem? ☐ Yes ☐ No

If yes, please list the attorney's name: _______________________________________

Past Medical History (circle all that you have experienced)

AIDS/HIV	Depression	Heart Attack/Angina	Anemia	Diabetes	Hepatitis C
Anxiety	Diverticulosis	High BP	Polio	Asthma	Endometriosis
Scoliosis	Bipolar	Rheumatic Fever	Cancer	Glaucoma	Irritable Bowel
Fibromyalgia	Jaundice	Irregular Heart	Seizures	Gastritis	Kidney Disease
Kidney Stone	Stroke	Thyroid Disease	COPD	Gout	STD
Blood Clot	Lupus	Liver Disease	Ulcers	Peripheral Vascular Disease	

Other problems: ____

Surgeries

Date	Surgery	Date	Surgery
_________	______________________	_________	______________________________
_________	______________________	_________	______________________________
_________	______________________	_________	______________________________

Work Status

Number of years at current job: _______ Are you currently employed? ☐ Yes ☐ No

If so: ☐ Regular duty ☐ Modified duty ☐ Working hrs / week __________

What are your restrictions? ____

Who wrote the restrictions? ____

Review of Systems

(In the past month, have you experienced any of the following? Please check each box.)

(If you have any of these symptoms, please notify your family doctor.)

HEENT

☐Blurred vision

☐Dry eyes

☐Hard of hearing

☐Nasal congestion

☐Sore throat

☐Cough

☐Other: __________

Integumentary

☐Moles

☐Skin rash

☐Other: ____________

Gastrointestinal:

☐Constipation

☐Diarrhea

General

☐Fevers

☐Chills

☐Night Sweats

☐Stress

☐Poor sleep

☐Feet swelling

☐Blood clots

Neurologic

☐Tremors

☐Other: ____________

Abdominal:

☐Abdominal pain

☐Other: ____________

Pulmonary:

☐Short of breath

☐Other: ________________

Cardiovascular:

☐Chest pain

Medications (Please list all the medications you are currently taking.)

Medication	Dose & times/day	Medication	Dose & times/day
______________________	_______________	__________________	______________
______________________	_______________	__________________	______________
______________________	_______________	__________________	______________
______________________	_______________	__________________	______________
______________________	_______________	__________________	______________
______________________	_______________	__________________	______________

Do you:

Smoke:	☐ yes ☐ no	_____Packs/day	_____ # of YRS.		
Past smoker?	☐ yes ☐ no	_____Packs/day	_____ # of YRS.	Quit Date_____	
Drink alcohol:	☐ yes ☐ no	_____ # drinks/week.			

TOBACCO AND SPINE HEALTH

Smoking and chewing tobacco is a leading risk factor in the development of degenerative disc disease. A disc is the shock absorber between the bones in your spine. When the disc starts to wear out it loses some of its ability to provide a "cushion" between bones. This allows for a greater risk of rupture.
The discs already have a poor blood supply and when you smoke or use tobacco the blood vessels constrict (narrow) and the oxygen supply is lowered even more. Smokers also introduce carbon monoxide into the blood stream which can inhibit the discs' ability to absorb needed nutrients from the blood. This leads to dehydrated discs and eventually degenerative disc disease.
If your spinal condition deteriorates enough to need a fusion surgery you will need to stop smoking or using tobacco. Nicotine is a bone toxin and can slow down new bone growth. The failure rate for many fusions can be 3 to 4 times higher for someone using tobacco. Many times you cannot have your surgery until you have been able to stop smoking or using tobacco.

There are a number of different options available to assist in smoking or tobacco cessation. Please let us know when you are ready to quit using tobacco.

If you are a current smoker, please initial and date here stating that you have read and understand the above smoking cessation recommendation:

____________	______________
Initials	Date

Family History

Relation	Age	State of health	If deceased, age and cause of death
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

As a patient at PremierOrtho, you may or may not be prescribed a controlled substance. If you are prescribed a controlled substance, we ask that you agree to our controlled substance protocol. If you will not accept our protocol, we cannot treat you, and you will need to work with another physician.

If prescribed such a medication, I agree to the following:

1. I am responsible for my controlled substance medications. If the medication is lost, misplaced, stolen, or I use it up sooner than prescribed, I understand that it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from PremierOrtho.
3. Refills or controlled substance medication:
    a. Will be made only during regular office hours Monday through Friday 8 am to 5 pm. Refills will not be made at night, on holidays, or weekends. I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription. Refill calls made on Friday will be made on Monday.
    b. Will not be if I "run out early". I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
    c. Will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
4. Upon request from my physician, if narcotic abuse is suspected, I may be asked to submit to a urine drug screen. If I decline, it will be at the sole discretion of PremierOrtho to discontinue my controlled substance.

Controlled substances are known to cause psychological dependence (addiction) which I understand is real. I know that some persons may develop a tolerance to medications in which may not respond as well to the medication. I know that I can become physically dependent on the medication. This will occur if I am on the medication several weeks, and when I stop the medication I must do so under medical supervision or I may have withdrawal symptoms.

I have read this agreement. I understand that if I do not follow the rules of this agreement, I will no longer be able to obtain medications from PremierOrtho.

______________________________ ______________________________

Patient Date Witness Date

____

Print Patient Name DOB