

BLUEGRASS ORTHOPAEDICS

Date: _____

ACCT #: _____

PATIENT INFORMATION:

Last Name: _____ First: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Sex: Male Female Marital Status: Single Married Divorced Widow

Are you employed? Yes No Employer Name: _____

Emergency Contact (not living with you): _____ Emergency Contact Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

SPOUSE/PARENT INFORMATION:

Last Name: _____ First: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employed? Yes No Employer Name: _____

Address: _____ City: _____ State: _____ Zip: _____

ALL PATIENTS: PLEASE FILL OUT HEALTH INSURANCE SECTION:

Health Insurance Company: _____ ID # _____

Secondary Insurance Company: _____ ID # _____

IS THIS WORKER'S COMP? IF SO, PLEASE COMPLETE:

Employer: _____

Name of W/C Carrier: _____

Address: _____

Address: _____

Telephone: _____

Telephone: _____

Date of Accident: _____

Claim #: _____ Adjuster Name: _____

IS THIS AUTO? IF SO, PLEASE COMPLETE:

Name of Auto Insurance Co: _____

Telephone: _____

Claim Office Address: _____

Claim/Policy: _____

Date of Accident: _____

****NOTICE****

Interest may be charged on all accounts which are transferred to collections at a rate of 1 1/2% per month, annual rate of 18%. I understand that interest charges will be added to any account I have that is 90 days or more past due and hereby agree to pay such charges if levied.

Signature/Date: _____

BLUEGRASS ORTHOPAEDICS & HAND CARE

PATIENT HISTORY

Please PRINT and fill out completely

Patient# _____

Name: _____

Today's Date: _____

Age: _____ Height: _____ Weight: _____ Hand Dominance: Left Right Respiration: _____

Referring Physician: _____ Primary Care Physician: _____

HISTORY OF INJURY:

Did the problem result from a specific injury? Yes No Injury/Accident Date: _____

Did your problems begin following: Work Injury Motor Vehicle Accident What State?: _____

How did you get injured?: _____

If neither, how long have you had the condition? _____

Please rate your pain on a scale of 1 to 10 (10 being the most painful): _____

Is the Pain: Constant Occasional Sharp Dull Aching Stabbing Throbbing

What symptoms are you experiencing? Locking Catching Giving Way Popping Grinding Other

What, if anything, makes your symptoms better? _____

What, if anything, makes your symptoms worse? _____

Have you seen another physician for this injury? Yes No

If yes, who? _____

What treatments have you tried? Nothing Physical Therapy Exercise Acupuncture

Chiropractic injections (specify: ESI, Facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)

Medications: _____ Other: _____

Have you ever had the following tests?

Test	Date (month/year)	What facility? (clinic/hospital)
<input type="checkbox"/> X-Rays	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

Regular Exercise: Yes No Type of exercise and activity you enjoy: _____

Patient Name: _____

Practitioner's Initials: _____

PAST SURGICAL HISTORY

Please check any previous surgical procedures, list the date and describe the surgery:

- Appendectomy Hernia Repair Arthroscopy – lower extremity Upper extremity
- Spine/Back surgery Heart surgery Total joint replacement Fracture repair
- Other: _____

SOCIAL HISTORY

- Special Diet: Yes No Any Restrictions? _____
- Tobacco Use: Yes No Type: _____ Duration: _____ Quit Date: _____
- Alcohol Use: Yes No Frequency? _____
- Drug Use: Yes No Frequency? _____
- Caffeine Use: Yes No Frequency? _____

ALLERGIES

- Latex: Yes No Metal Allergies (Earrings): _____ Nickel Allergy
- Are you allergic to any medication: Yes No
- Please list all medications that you are allergic to: _____

MEDICAL HISTORY

Please check current or previous medical conditions:

- Anemia Depression Hepatitis A or B Osteoporosis
- Arthritis Diabetes High Blood Pressure Rheumatoid Arthritis
- Asthma Emphysema HIV Stroke/Seizures
- Blood Clots Heart Disease Irregular Heartbeat Thyroid
- Cancer Liver Disease Chemical Dependency and/or Alcoholism
- Other: _____

Have you ever had a blood transfusion? Yes No If yes, when? _____

MEDICATIONS

Please list medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin and any over the counter medications. Include Vitamin, Mineral and herb supplements.

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? Yes No If yes, when? _____

Do you have a history of GI, Stomach bleed? Yes No If yes, when? _____

Do you take any medications for your stomach? (Please include over the counter medications, i.e. Pepcid, Tums, Zantac, etc., dosage and frequency). _____

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include over the counter medications such as Advil, Aleve and previously prescribed medications, such as Celebrex and Vioxx. List all you have tried).

Patient Name: _____

Practitioner's Initials: _____

FAMILY HISTORY

Please check family history conditions:

- | | | | |
|--------------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke/Seizures |

Please describe any immediate family history of medical problems: _____

REVIEW OF SYMPTOMS

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems, please check in the negative box.

- | | | | | | |
|------------------------------|---|--|---|---|--|
| 1. CONSTITUTIONAL
GENERAL | <input type="checkbox"/> None | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Chronic Fatigue |
| | <input type="checkbox"/> Other: _____ | | | | |
| 2. EYES | <input type="checkbox"/> None | <input type="checkbox"/> Vision Change | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| | <input type="checkbox"/> Other: _____ | | | | |
| 3. EARS, NOSE, THROAT | <input type="checkbox"/> None | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Sinus Pain | <input type="checkbox"/> Ringing |
| | <input type="checkbox"/> Other: _____ | | | | |
| 4. CARDIOVASCULAR | <input type="checkbox"/> None | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Edema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Palpitations |
| | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other: _____ | | | |
| 5. RESPIRATORY | <input type="checkbox"/> None | <input type="checkbox"/> Asthma | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Frequent Cough | |
| | <input type="checkbox"/> Other: _____ | | | | |
| 6. GASTROINTESTINAL | <input type="checkbox"/> None | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Ulcer Problems |
| | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> GI Stomach Bleed | | |
| | <input type="checkbox"/> Other: _____ | | | | |
| 7. MUSCULOSKELETAL | <input type="checkbox"/> None | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Back Pain |
| | <input type="checkbox"/> Other: _____ | | | | |
| 8. SKIN | <input type="checkbox"/> None | <input type="checkbox"/> Rash | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Scars | |
| | <input type="checkbox"/> Other: _____ | | | | |
| 9. NEUROLOGICAL | <input type="checkbox"/> None | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness | <input type="checkbox"/> Dizziness |
| | <input type="checkbox"/> Other: _____ | | | | |
| 10. PSYCHIATRIC | <input type="checkbox"/> None | <input type="checkbox"/> Depression | <input type="checkbox"/> Crying | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mood Swing |
| | <input type="checkbox"/> Other: _____ | | | | |
| 11. ENDOCRINE | <input type="checkbox"/> None | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Hot Flashes |
| | <input type="checkbox"/> Other: _____ | | | | |
| 12. HEMATOLOGY | <input type="checkbox"/> None | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Anemia | |
| | <input type="checkbox"/> Other: _____ | | | | |

Signature: _____

Date: _____

Print Name: _____

**BLUEGRASS ORTHOPAEDICS & HAND CARE
NARCOTIC PAIN MEDICATION AGREEMENT**

Patient Name: _____
Social Security Number: _____
Date: _____
Pharmacy Name: _____
Account Number: _____

To the Patient:

It is our policy at Bluegrass Orthopaedics that patients receiving prescriptions for narcotic medication are required to sign a Narcotic pain medication Agreement. The Narcotic pain Medication Agreement includes questions about the patient's previous history of controlled substance abuse, consent for Bluegrass Orthopaedics to obtain information from and provide information to the patient's pharmacist and other providers, and describes restriction on use of narcotic pain medication.

Please answer the following questions:

1. Have you ever been diagnosed with or treated for substance abuse? Yes No

If yes, please explain: _____

2. Have you ever been arrested for illegal possession of a controlled substances? Yes No

If yes, please explain: _____

3. By signing this agreement:

- I agree that the medication will be stopped should my functional ability not improve, should it lose its effectiveness, or should I be found to be misusing the medications in any way.
- I understand that this medication is potentially addictive and the chances of addiction are greatly decreased if these medications are prescribed to me in a strict and controlled environment under the guidance of my physician. I understand this includes regular office visits to assess my progress.
- I agree to take the medication only as prescribed and will not change the dose without getting approval from my physician. I understand that my physician may not approve the changes in dosage.
- I will obtain pain medication prescriptions only from the doctor named above. Violation of this requirement will result in tapering and discontinuing of the drug. In the event that this doctor is not available to write the prescription when due, I understand that only a partial prescription will be given until my physician returns.
- No prescription that is "lost, misplaced or stolen" will be replaced. Using too much of these medications will not be tolerated and the prescription will not be filled early for any reason. I understand the Drug Enforcement Agency has strict guidelines forbidding these actions and my physician must abide by these rules.
- If I am unable to tolerate my medication, I will return the unused portion of the medication to my physician, before I am given a prescription for another similar medication.
- I understand that, at some point in my treatment, my physician will discuss with me a scheduled taper and or discontinuation of the medication and I agree to follow this schedule.

4. Medical release of information – I hereby authorize Bluegrass Orthopaedics to obtain and release medical information from/to physicians, clinics, hospitals, or other health care providers including pharmacies:

Witness by BGO Staff Member

Date

Patient Signature, Guardian if patient is a minor

Date