

ORTHOBETHESDA

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CLINICAL INFORMATION SHEET - Your insurance company **requires** that we obtain this information. Please fill out **completely!**

PATIENT'S NAME _____ HEIGHT: _____ ft. _____ in. WEIGHT _____ AGE _____

PRIMARY CARE (REFERRING) _____ REFERRING **PHYSICIAN**
PHYSICIAN _____ IF DIFFERENT _____

WE WILL SEND OFFICE NOTES TO THE ABOVE PHYSICIANS UNLESS OTHERWISE DIRECTED

ARE YOU STAYING AT A SKILLED NURSING FACILITY? _____ **WHERE?** _____

MEDICAL HISTORY: Please circle if you have, or have had, any of the following: NONE

- | | | | | |
|----------------------|---------------------------|---------------------|--------------------------|------------------------------|
| 1. Diabetes | 4. Heart Arrhythmia | 7. Heart Attack | 10. Rheumatoid Arthritis | 13. Stomach/Duodenal Cancer |
| 2. Stroke | 5. Coronary Heart Disease | 8. High Cholesterol | 11. Liver Disease | 14. Gastro/Esoph/Acid Reflux |
| 3. TIA (mini stroke) | 6. High Blood Pressure | 9. Depression | 12. Kidney Disease | 15. Cancer (type) _____ |
| | | | | 16. Osteoarthritis |

OTHER _____

SURGICAL PROCEDURES: Have you ever had any surgery? YES NO If yes, please circle:

- | | | | | |
|------------------|--------------------|-------------------------|------------------------|---------------------------|
| 1. Heart Surgery | 3. Vascular Bypass | 5. Angioplasty | 7. Appendectomy | 9. Carotid Endarterectomy |
| 2. Hernia Repair | 4. Hysterectomy | 6. Cancer Surgery _____ | 8. Gallbladder Surgery | Date of Surgery: _____ |

Please list any *orthopaedic surgeries* you have had: _____

REVIEW OF SYMPTOMS: Are you currently having, or have you ever had, problems with: NONE

- | | | |
|--|--|---|
| Lungs or Breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart or Chest Pain? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| GI Ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness or Tingling? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

SOCIAL HISTORY:

Do you smoke? Yes No Do you drink alcohol? Yes No Do you exercise regularly? Yes No

MEDICATIONS: Do you take any medications, including aspirin and other non-prescription medications? Yes No
If yes, please list: _____

ALLERGIES: Are you allergic to any medications, environmental substances, or metals? Yes No If yes, please list.

WHAT PART OF THE BODY ARE YOU HERE FOR TODAY? _____ LEFT RIGHT
WHEN DID THIS PROBLEM BEGIN?* _____

*IF ONGOING, PLEASE INDICATE TIME PERIOD OF MOST RECENT EPISODE OR "FLARE-UP:"

WAS THERE A SPECIFIC INJURY? Yes No **If yes, briefly describe incident:** HOME WORK OTHER

PAST HISTORY – Have you had previous problems with this area? Yes No
If yes, please describe: _____

HAVE YOU SEEN ANY OTHER PHYSICIANS FOR THIS PROBLEM? Yes No Physician _____

WERE X-RAYS TAKEN? Yes No IF YES, DID YOU BRING THE X-RAYS WITH YOU? Yes No

WERE ANY OTHER TESTS PERFORMED? Yes No IF YES, DID YOU BRING THE TEST RESULTS WITH YOU? Yes No

IF FEMALE: IS THERE ANY POSSIBILITY THAT YOU ARE PREGNANT? Yes No

* The above is true and correct to the best of my knowledge.

PATIENT SIGNATURE _____ **DATE** _____

REVIEWED BY _____ **DATE** _____