COLUMBUS ORTHOPAEDIC CLINIC & OUTPATIENT CENTER

Dr. Hall New Patient Paperwork

Please fill out these forms completely

Date of Appointment _____

Complete the enclosed packet and bring it to the appointment along with all X Rays, MRI disc and reports.

Please bring your insurance cards and picture ID

Providing high-quality care and patient satisfaction is important to us at Columbus Orthopaedic Clinic and Outpatient Center. Please understand that each patient will receive individualized care. Because of this variability in your appointment may not start at your designated time. We appreciate your cooperation.

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Referred By: _____

Please fill out these forms completely!

We know that filling out these forms can be difficult - but please complete them carefully. Your accurate responses will give us a better understanding of you and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes, and fill in the blanks where indicated. Thank you for helping us to know you better!

Date: _____

Patient Name: _____
(please print)

Gender: Male Female

Date of Birth: _____
(month/day/year)

Current Age: _____

FACTORS OF COMPLAINT

What is bothering you most at this time?

What do you want to happen as a result of this visit?

How and when did your problem begin?
(Please mark each answer that applies to your neck/back pain.)

I don't know how it began.
It comes and goes.
I've had it a long time. (_____years)
Injury (date of injury_____) On the job? ◯yes ◯no
Please explain how the injury happened.

_____

Are you currently in litigation with regards to your back pain?
◯yes ◯no
Have you been laid off from your job? ◯yes ◯no ◯N/A

Do you have any of the following problems?
(Please check your answer.)

Is your pain worse at night? ◯yes ◯no
Does your pain awaken you from sleep? ◯yes ◯no
Does coughing affect your pain? ◯yes ◯no
Do your legs tire/hurt if you walk too far? ◯yes ◯no
If YES, how far can you walk?
◯less than 1 block ◯1-3 blocks ◯more than 3 blocks
Is this relieved by resting your legs? ◯yes ◯no
Is this relieved by bending forward? ◯yes ◯no

Bladder Control (urine):

◯ No problem
◯ Can't empty bladder
◯ Loss of urine (accidents)

Bowel Control:

◯ No problem
◯ Constipation
◯ Loss of control (accidents)

How does each of the following affect your pain? (check your answer)

Sitting	◯ Better	◯ Worse	◯ No change	
Standing	◯ Better	◯ Worse	◯ No change	
Walking	◯ Better	◯ Worse	◯ No change	
Lying down	◯ Better	◯ Worse	◯ No change	
Rising from chair	◯ Better	◯ Worse	◯ No change	
Physical activity	◯ Better	◯ Worse	◯ No change	
Heat	◯ Better	◯ Worse	◯ No change	◯ Don't know
Cold	◯ Better	◯ Worse	◯ No change	◯ Don't know

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GENERAL MEDICAL HISTORY

Check all the conditions below that you have currently or have had in the past. If NONE check

- Heart attack
- Heart murmur
- Angina
- High blood pressure
- Stroke
- Varicose veins
- Stomach ulcer
- Duodenal problems
- Anemia (low blood count)
- Colon problems
- Diabetes
- Hepatitis
- Cirrhosis
- Kidney stones
- Kidney infection
- Degenerative arthritis
- Rheumatoid arthritis
- Bleeding tendency
- Gout
- Anxiety
- Depression
- Emphysema
- Tuberculosis
- Chronic bronchitis
- Frequent pneumonia
- Asthma
- Sexual difficulty
- Enlarged prostate
- Menstrual problems
- Cancer: type_____
- Osteoporosis

Have you used :
- Immuno-suppression?
- Corticosteroids

Other_____

List any major surgery you have had, other than on your back or neck.

Type of surgery	Year
1. _____	_____
2. _____	_____
3. _____	_____

Have you ever had surgery on your back or neck?

Type of surgery	Year	Surgeon	Did it make your pain
1. _____	_____	_____	Better or Worse
2. _____	_____	_____	Better or Worse
3. _____	_____	_____	Better or Worse

SOCIAL HISTORY

Marital Status
- Married
- Separated
- Divorced
- Single
- Widow/widower

Education
Check the highest level completed:
- Grammar school
- High school
- College
- Post-graduate

Smoking
- Current Every Day Smoker
- Current Some Day Smoker
- Former Smoker
- Never Smoker
- Smoker – Current Status Unknown
- Unknown If Ever Smoked

Patient Smokes: Every Day Some Days
Year Started _____
Cigarettes Amt: _____ packs/day
Cigars Amt: _____ # per week
Smokeless/Chewing Amt: _____per Day
Has had tobacco cessation counseling

Alcohol
Do you drink:
Beer: yes no Amt: _____per day
Wine: yes no Amt: _____glasses/day
Hard" drinks: yes no Amt: _____ day

Frequency of drinking:
- never
- rarely Amt: ____ drinks/day
- socially
- daily

Do you have a history of heavy drinking?
yes no

Please indicate your current work status.
- Working full time
- Working part time
- Seeking employment
- Not working by choice (retired, homemaker, student, etc.)
- Physically unable to work due to back/neck problem
- Physically unable to work not due to back/neck problem

Before having back or neck pain, did you normally work:
full time part time neither
What is your usual occupation?
_____
Do you like your work situation?
yes no N/A

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FAMILY MEDICAL HISTORY

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:
Check all that apply:

- ◯ Stroke
- ◯ Diabetes
- ◯ Lung disease
- ◯ High Blood Pressure
- ◯ Heart trouble
- ◯ Back problems
- ◯ Cancer
- ◯ Osteoporosis
- ◯ Scoliosis
- ◯ Kyphosis
- ◯ Arthritis
- ◯ None of these
- ◯ Don't know
- ◯ Other

REVIEW OF SYSTEMS

Do you have any of the following?

General:

Recent weight loss of more than 10 pounds?	◯ yes ◯ no
Recent weight gain of more than 10 pounds?	◯ yes ◯ no
Fever?_____	◯ yes ◯ no
Chills?_____	◯ yes ◯ no
Night sweats? _____	◯ yes ◯ no

Have you seen your primary care physician in the past year? ◯ yes ◯ no

Cardiac:

Chest pain	◯ yes ◯ no
Shortness of Breath	◯ yes ◯ no

Respiratory:

Wheezing	◯ yes ◯ no
Pneumonia	◯ yes ◯ no
Chronic cough	◯ yes ◯ no

Gastrointestinal:

Abdominal pain	◯ yes ◯ no
Nausea	◯ yes ◯ no
Vomiting	◯ yes ◯ no
Diarrhea	◯ yes ◯ no
Liver problems	◯ yes ◯ no

Skin:

Open sores	◯ yes ◯ no
New moles	◯ yes ◯ no
Poor healing	◯ yes ◯ no
Skin infection	◯ yes ◯ no

Hematoligic/Oncologic:

Easy bruising	◯ yes ◯ no
Blood thinning medications	◯ yes ◯ no
Blood transfusion	◯ yes ◯ no
Organ transplant	◯ yes ◯ no

Bones/Joints:

Shoulder pain	◯ yes ◯ no
Wrist/hand pain	◯ yes ◯ no
Hip pain	◯ yes ◯ no
Knee pain	◯ yes ◯ no
Lupus	◯ yes ◯ no
Muscle weakness	◯ yes ◯ no
Fibromyalgia	◯ yes ◯ no

Genitourinary:

Abnormal kidney function	◯ yes ◯ no
Pain with urination	◯ yes ◯ no
Frequent urinary infections	◯ yes ◯ no

Mental Health:

Sleep disturbances	◯ yes ◯ no
Feeling of hopelessness	◯ yes ◯ no

Nervous System:

Headaches	◯ yes ◯ no
Tremors	◯ yes ◯ no
Poor speech	◯ yes ◯ no
Changes in vision	◯ yes ◯ no

Endocrine:

Thyroid problems	◯ yes ◯ no

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Are you allergic to any medications, foods or environmental substances?

yes no If YES, list the medications.

_____

_____

_____

_____

Medication Name:	Dose and Instructions:	Prescribing Physician:
Ex. Ibuprofen	800mg Once daily	Dr. John Smith
1.		
2.		
3.		
4.		
5.		
6.		
7.		
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20.		
21.		
22.		
23.		

Return, medication list, new patient paperwork, and all prior imaging (disc and written report), as well as any medical records you have for your back or neck, prior to your appointment.