



PREFERRED ORTHOPEDICS

OF THE PALM BEACHES

PATIENT # _____

REGISTRATION FORM

CIRCLE ONE:

WORKERS COMPENSATION YES* NO

TODAY'S DATE _____ TREATING PHYSICIAN _____

MEDICAL CONDITION SEEN FOR TODAY _____ DATE OF ACCIDENT / INJURY _____ / _____ / _____ DATE PROBLEM BEGAN _____ INITIAL

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ / _____ / _____ AGE _____ SEX: M F

HOME PH.# _____ MOBILE/CELL # _____ WORK PH. # _____ X

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP _____

OUT-OF-STATE ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY LANGUAGE _____ MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED SEPERATED

REFERRED BY (CIRCLE ONE BELOW) I would like to receive updates via email. Yes EMAIL: _____

FAMILY PHYSICIAN INTERNET COMMUNITY NEWS

PATIENT REFERRAL YELLOW PAGES OTHER: _____ PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE _____ INSURANCE ID # _____

SUBSCRIBER'S LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

SUBSCRIBER'S SOCIAL SECURITY # _____ SUBSCRIBER'S SEX M F SUBSCRIBER'S DATE OF BIRTH _____ / _____ / _____

PATIENT RELATIONSHIP TO SUBSCRIBER _____ PLAN EFFECTIVE DATE _____

SUBSCRIBER'S EMPLOYER _____

SECONDARY INSURANCE INFORMATION

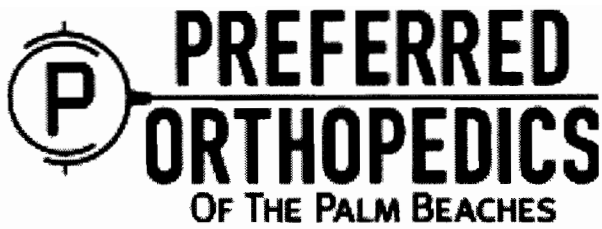
NAME OF INSURANCE _____ INSURANCE ID # _____

SUBSCRIBER'S LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

SUBSCRIBER'S SOCIAL SECURITY # _____ SUBSCRIBER'S SEX M F SUBSCRIBER'S DATE OF BIRTH _____ / _____ / _____

PATIENT RELATIONSHIP TO SUBSCRIBER _____ PLAN EFFECTIVE DATE _____

SUBSCRIBER'S EMPLOYER _____



Confidential Health History

Gregory M. Martin, M.D.
Board Certified Orthopedic Surgeon
Specializing in Hip and Knee

Patient Name: _____

Date: _____ Time: _____

Age: _____ Birthdate: _____

Who Referred You? _____

Primary Care Doctor? _____

What is the Reason for today's visit? _____

When did problem start? Date _____

Was there an injury? No Yes If Yes, Describe _____

How long has this been going on (circle one): Days Weeks Months Years

Please Circle all areas with Pain and or Functional Problem:

Low Back	Right	Left	Other (please write in space below):
Hip	Right	Left	
Buttock	Right	Left	
Groin	Right	Left	
Thigh	Right	Left	
Knee	Right	Left	
Leg (below knee)	Right	Left	

What is the intensity of the pain on a scale of 0 to 10 (10 being severe/unbearable)? _____

Pain feels like (circle all that apply): Sharp Dull Throbbing Stabbing Burning

Pain is (circle all that apply): Constant Intermittent Daily Weekly

Pain occurs with (circle all that apply): Activity (eg. Walking, sports, etc) Rest Sleep

Pain improves with (circle all that apply) Activity Rest Sleep Other _____

Pain worsens with (circle all that apply): Activity Rest Sleep Other _____

Is there any associated Locking, Catching or Buckling? Yes No

Any numbness or tingling in legs? No Yes Right leg Left leg

Do you Limp? No Yes

Is there any trouble getting dressed, tying shoes, or clipping toenails? No Yes

Do you use a walking aid(circle all that apply)? No Cane Walker Wheelchair

Do you feel a difference in the length of your legs? No Yes

If yes, which leg feels longer? Right Left

What have you done or taken to help (circle all below that apply)?:

Tylenol Allelevelbuprofen(Motrin/Advil) Ice Heat Brace Ointments

Glucosamine/Chondroitin Other_____

Have you taken any prescription pain pills or prescription anti-inflammatories? Yes No

Vicodin/hydrocodone Percocet/oxycodone Mobic/meloxicam Naprosyn Celebrex

Other(please list)_____

Have you had any injections? No Yes Where? Back Hip Knee Side Right Left

If Yes, what was injected (circle all that apply)?

Cortisone Viscosupplement (synvisc, hyalgan, supartz, orthovisc, euflexxa)

Of the above, what has helped the most?_____

Past Surgical History (circle all that apply, list Surgeon, Hospital and date performed):

None

Spinal Surgery_____

Hip R L _____

Knee R L _____

Other Surgery: _____

Do you have any allergies to medications? No Yes (please list)_____

Please list current Medications/Doses:

Is there any past or current history of:

Anemia? No Yes
Blood Clot/Venous Thrombosis? No Yes
Pulmonary embolus? No Yes
Sickle Cell? No Yes

Angina/chest pain? No Yes
Heart arrhythmia? No Yes
Heart attack? No Yes
Heart disease? No Yes

High Blood Pressure? No Yes
High Cholesterol?

Asthma? No Yes
COPD/Emphysema? No Yes

Cancer? No Yes If Yes, Type? _____

Diabetes? No Yes

***Please list any other pertinent past medical history not identified below:**

Epilepsy/seizures? No Yes
TIA or Stroke? No Yes

Kidney disorders? No Yes
Gastritis? No Yes
Hepatitis? No Yes
Ulcers? No Yes

Thyroid disease? No Yes

Peripheral vascular disease? No Yes

Osteoarthritis? No Yes
Rheumatoid arthritis? No Yes
Psoriatic arthritis? No Yes
Gout? No Yes

Social History:

Marital Status: Single Married Divorced Widowed Separated

Any Children?: No Yes Number _____ Parents: Living Deceased

Do you smoke tobacco products? No Yes Packs/day? _____ #Years _____

Do you drink alcohol? No Yes Type? _____ How much? _____

Do you use prohibited substances? No Yes Type? _____

Circle current work status: Employed Retired Disabled Unemployed

List current/former occupation: _____

Family History (Parents, Siblings, Children)(Circle all that apply):

High Blood Pressure Heart Disease Stroke Diabetes Thyroid Disease
Cancer Arthritis Kidney Disease Other _____

Review of Systems (Are any of the following symptoms present? Circle all that apply):

<u>Constitutional:</u>	<u>Fevers</u>	<u>Chills</u>	<u>Night sweats</u>	<u>Fatigue</u>
<u>Eyes:</u>	<u>Double vision</u>	<u>Watery eyes</u>	<u>Itching eyes</u>	<u>Eye pain</u>
<u>EarNoseThroat:</u>	<u>Nose bleeds</u>	<u>Bleeding gums</u>	<u>Hoarseness</u>	<u>Swollen glands</u>
<u>Cardiovascular:</u>	<u>Chest pain</u>	<u>Palpitations</u>	<u>Swollen ankles</u>	<u>Fainting</u>
<u>Respiratory:</u>	<u>Cough</u>	<u>Sputum</u>	<u>Wheezing</u>	<u>Shortness of Breath</u>
<u>Gastrointestinal:</u>	<u>Heartburn</u>	<u>Reflux</u>	<u>Jaundice</u>	<u>Nausea</u>
<u>GenitoUrinary:</u>	<u>Frequency</u>	<u>Burning</u>	<u>Incontinence</u>	<u>Sexual Dysfunction</u>
<u>Neurologic:</u>	<u>Numbness</u>	<u>Dizziness</u>	<u>Weakness</u>	<u>Balance issues</u>
<u>Endocrine:</u>	<u>Excessive thirst</u>	<u>Weight gain</u>	<u>Weight loss</u>	<u>Heat/Cold intolerance</u>
<u>Hematologic:</u>	<u>Easy bruising</u>	<u>Bleeding problems</u>	<u>Previous Blood Transfusion</u>	
<u>Psychiatry:</u>	<u>Anxiety</u>	<u>Depression</u>	<u>Mood Changes</u>	<u>Nervousness</u>
<u>Allergy:</u>	<u>Itching</u>	<u>Environmental</u>	<u>Food Allergies</u>	
<u>Skin:</u>	<u>Rashes</u>	<u>Hives</u>	<u>Psoriasis</u>	<u>Nonhealing wounds</u>
<u>Musculoskeletal:</u>	<u>Joint pain</u>	<u>Joint swelling</u>	<u>Stiffness</u>	<u>Cramps</u>

Please list any other thing you believe is important to let the doctor know?

Height_____ **Weight**_____

Initial Visit Attestation:

I have read and answered the above questions. I affirm that they are complete and true to the best of my knowledge and belief.

Patient Signature: _____ Date: _____

Provider Attestation:

I have personally reviewed and gathered the above information on the date noted below.

Physician Signature: _____ Date: _____