# Orlin & Cohen Medical Specialists Group

Sports Medicine, Joint Replacement, Arthroscopy & Reconstructive Surgery, Foot & Ankle Surgery,
Knee & Shoulder Reconstruction, Spinal Surgery & Pain Management, Hand & Elbow Surgery, Trauma

Patient Label

## NEW PATIENT INFORMATION FORM

LAST _____ M.I. _____ FIRST _____

STREET # & NAME OR P.O. BOX _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SS # _____ DOB _____ SEX _____ E-MAIL _____

NAME OF SPOUSE/PARTNER/GUARDIAN (EMERGENCY CONTACT) _____ PHONE _____

REFERRING PHYSICIAN NAME _____ ADDRESS _____ PHONE _____

PRIMARY CARE PHYSICIAN NAME _____ ADDRESS _____ PHONE _____

INSURANCE: PRIMARY _____ SECONDARY _____

INSURED _____ EMPLOYER _____ INSURED DOB _____

CURRENT SCHOOL INCLUDES GRADE LEVEL _____ SPORTS/OCCUPATION INCLUDE POSITIONS _____

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports / Light Duty / Not working due to the Injury

Does this visit involve a workman's Compensation issue? YES / NO Hand Dominance: ❑ LEFT ❑ RIGHT

Was your injury reported to your employer ❑ Yes ❑ No

**Chief Complaint / History of Present Illness:** Height_____ Weight_____

Body Part Injured: LEFT / RIGHT_____ Cause: Sports/Work/Auto/Other

Date of Injury/Accident/Onset: _____ Time & were _____

How did the Injury Occur?_____

_____ Was Injury ❑ Gradual ❑ Sudden ❑ Repetitive Motion

How does it affect / bother you?_____

Pain at Rest: (No Pain) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

Pain at Activity: (No Pain) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

Does anything make your pain better or worse? (Please list) _____

Have you been treated for this problem before? YES / NO Date(s):_____

By whom? _____

Prior surgery for this problem? YES / NO Date(s): _____

Physical therapy for this problem? YES / NO Date(s):_____

If you were/are unable to work/play, list dates of disability:_____ to _____

Have you had any prior tests or imaging studies for this problem? YES / NO

If yes, list facility, type & date: _____

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**Past Medical History: (PHX)** *Please list none if the question does not apply.*

Medical Problems: _____

_____

Previous Hospitalizations & Surgical Procedures: (Provide Dates) _____

_____

_____

Please list all allergies (drug, food, environmental): _____

_____

Current Medications: (Include Doses and Frequency) _____

_____

_____

**Family Medical History:** (Include Medical Illness Affecting Patient's Immediate Family)_____

_____

**Social History:** (Check Boxes and Fill Blanks)

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other:_____

Alcohol Use: ❑ Occasional ❑ Daily ❑ Heavy ❑ None

Tobacco Use: ❑ Yes ❑ No (Type:_____Packs Per Day_____Years Used:_____)

Recreational Drug Use: ❑ Yes ❑ No (Types):_____ _____)

**REVIEW OF SYSTEMS:** (Check All That Apply)

GENERAL
❑ Weight Change
❑ Fever or Chills
❑ AIDS/HIV
❑ Night Sweats
❑ Bleeding
❑ Lumps or Masses
❑ Dizziness or Fainting
❑ Diabetes Mellitus
❑ Thyroid Problem
❑ Cancer

EAR-EYES-NOSE-THROAT
❑ Visual Change
❑ Hearing Change
❑ Tinnitus
❑ Bleeding Gums

MUSCULOSKELETAL
❑ Back Ache
❑ Joint Pain
❑ Joint Swelling

GASTROINTESTINAL
❑ Difficulty Swallowing
❑ Jaundice
❑ Hepatitis
❑ Reflux
❑ Ulcer

CARDIOVASCULAR
❑ Chest Pain
❑ Heart Disease
❑ High Blood Pressure
❑ Mitral Valve Prolapse
❑ Thrombohlebitis/DVT/PE

RESPIRATORY
❑ Cough/Sputum
❑ Tuberculosis
❑ Shortness of Breath
❑ Asthma
❑ Emphysema

❑ All Systems Reviewed & Negative

GENITOURINARY
❑ Urinary Infections
❑ Incontinence
❑ Urinary Frequency
❑ Veneral Disease
❑ Menopause

NEUROLOGIC
❑ Seizures
❑ Numbness
❑ Weakness

PSYCHOLOGICAL
❑ Depression
❑ Bipolar
❑ ADD/ADHD
❑ Other

SKIN
❑ Itching or Rash
❑ Wound Discharge

**Providers Notes Section:**

## Pharmacy Information Sheet

We can send your prescriptions directly to your pharmacy so that there is less waiting time for you. If you know your pharmacy, please complete the below form. Please be aware that the easiest way for us to find your pharmacy is to know the zip code.

| | | |
|---|---|---|
| Your Name: | Date of Birth: | |
| Pharmacy Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Pharmacy Phone #: | Pharmacy Fax: | |

_____ _____ _____ _____

Patient/Guardian Signature | Date | Physician's Signature | Date