Name:
DOB:
Chart:
Age:
Date:

ORTHOPAEDIC SPECIALISTS of Northwest Indiana

Patient Medical History

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Have you ever been treated for this problem before? ☐ Yes ☐ No

Date of Injury/ Onset of problem _____

Current problem is a result of: *Check all that apply:*

☐ Car Accident ☐ Work Accident ☐ Other *(specify)* _____

MEDICAL HISTORY

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Kidney Problems	☐	☐	Pulmonary Embolism
☐	☐	Arthritis	☐	☐	Gallbladder Problems	☐	☐	Liver Disease	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Gout	☐	☐	Lung Problems	☐	☐	Sexually Transmitted Disease
☐	☐	Birth Defects	☐	☐	Heart Disease	☐	☐	Phlebitis			
☐	☐	Bladder Problems	☐	☐	Hepatitis	☐	☐	MRSA / Staph Infection	☐	☐	Stroke / TIA
☐	☐	Bleeding or Bruising	☐	☐	HIV / AIDS	☐	☐	Osteoporosis	☐	☐	Tuberculosis
☐	☐	Cancer Type _____	☐	☐	High Blood Pressure	☐	☐	Peripheral Vascular Disease	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	High Cholesterol				☐	☐	Ulcer Type _____
☐	☐	DVT / Blood Clots	☐	☐	Intestinal/ Bowel Problems	☐	☐	Polio			
						☐	☐	Psychological problems			

Are there any other medical problems we should know about? _____

Are you right or left-hand dominant? ☐ Right ☐ Left

Are you or could you be pregnant? ☐ Yes ☐ No

Do you exercise or participate in sports regularly? ☐ Yes ☐ No

Type and Frequency: _____

MEDICATIONS *Please list all medications you take with or without a prescription (use extra paper if needed)*

Medication Name	Dosage / # per day	Reason for taking

ALLERGIES *Please describe any current or past allergic reactions*

Allergy to (drug)	Reaction (itching, cough, hives, etc)	How was / is the reaction treated?

☐ I DO NOT have any allergies

SURGERIES AND HOSPITALIZATIONS

☐ Arthroscopy _____ Year _____ Physician _____ Complication? _____

☐ Joint replacement _____ Year _____ Physician _____ Complication? _____

☐ Bone or joint reconstruction _____ Year _____ Physician _____ Complication? _____

☐ Spine surgery _____ Year _____ Physician _____ Complication? _____

☐ Other general surgery _____ Year _____ Physician _____ Complication? _____

_____ Year _____ Physician _____ Complication? _____

☐ Other hospitalizations _____ Year _____ Physician _____ Complication? _____

☐ I HAVE NOT HAD any surgeries or hospitalizations

Name:
DOB:
Chart:
Age:
Date:

FAMILY HISTORY

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	Osteoporosis	Other_____
☐	☐	Arthritis	☐	☐	Gout	☐	☐	Stroke	_____
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Sudden Death	_____

SOCIAL HISTORY

Do you smoke or chew tobacco? ☐ Yes ☐ No Number: ____ packs per day for _____ years
Do you drink alcoholic beverages? ☐ Yes ☐ No Amount and frequency: _____
Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: _____

REVIEW OF SYSTEMS

Please check the following symptoms you have experienced on a regular basis:

GENERAL
☐ Fever
☐ Weight change
☐ Hormonal problems
☐ Other _____
☐ NONE

CARDIOVASCULAR
☐ Chest pain
☐ Palpitations
☐ Fluid/ Swelling in extremities
☐ Other _____
☐ NONE

KIDNEY/ BLADDER
☐ Painful urination
☐ Frequent urination
☐ Incontinence
☐ Other _____
☐ NONE

EYES
☐ Glasses/ Contacts
☐ Cataracts
☐ Glaucoma
☐ Other _____
☐ NONE

RESPIRATORY
☐ Shortness of breath
☐ Sleep apnea
☐ Wheezing
☐ Other _____
☐ NONE

EARS, NOSE, THROAT
☐ Difficulty swallowing
☐ Ear pain
☐ Seasonal allergies
☐ Hard of hearing
☐ Other _____
☐ NONE

GASTROINTESTINAL
☐ Heartburn
☐ Diarrhea/ Constipation
☐ Abdominal pain
☐ Nausea/ vomiting
☐ Other _____
☐ NONE

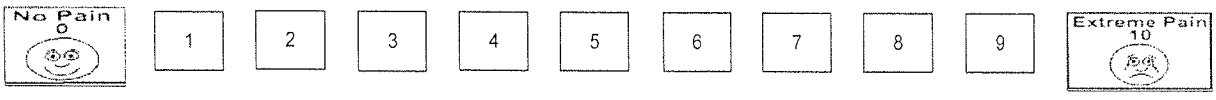
SKIN
☐ Rashes
☐ Lumps
☐ Other _____
☐ NONE

HEMATOLOGIC/ LYMPHATIC
☐ Anemia
☐ Blood problems
☐ Clotting disorder
☐ Lymph Problems
☐ Other _____
☐ NONE

NEUROLOGICAL
☐ Headaches
☐ Numbness
☐ Tingling
☐ Seizures
☐ Weakness
☐ Other _____
☐ NONE

PSYCHOLOGICAL
☐ Anxiety
☐ Depression
☐ Mood swings
☐ Other _____
☐ NONE

Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1 -10.



Patient Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Name:
DOB:
Chart: Date:
Age:

Authorization for Treatment - I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information/Medical Record Diagnosis - I hereby authorize the physician(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employers workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information. I will be held personally responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits / Financial Obligation - In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to Insufficient Funds.

Co-payments - I understand that if my medical insurance requires a co-pay or encounter fee the payment is due AT THE TIME OF SERVICE.

Patient Signature	Date	Responsible Party Signature	Date
Witness Signature	Date	Relationship to Patient	Date

I give consent and authorization to release my medical information to the following:

_____ (Name/ Relationship)
_____ (Name/ Relationship)
_____ (Name/ Relationship)

I give consent and authorization to release my billing information to the following:

_____ (Name/ Relationship)
_____ (Name/ Relationship)
_____ (Name/ Relationship)

(Section 2) AUTHORIZATION TO REQUEST SERVICE OR TREATMENT OF A MINOR

I give my consent and authorization for persons I list below to have the right and privilege to request service and treatment for all minors listed on the other side of this form, should I not be present or available by telephone. This authorization is subject to revocation at any time and must be clone in writing, except to the extent that action has already been taken in reliance on the consent.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

I understand I may revoke the privilege listed in (Section 1) and (Section 2) at any time by submitting my request in writing to this office.

Patient/Parent/Guardian Signature _____ DATE _____

ADVANCED DIRECTIVE

Have you appointed a Health Care Representative? yes___ no___ Do you have a living will? yes___ no___
Have you given anyone your Power of Attorney? yes___ no___

Name:
DOB:
Chart:
Age:
Date:

ORTHOPAEDIC SPECIALISTS of Northwest Indiana

New Problem Questionnaire

Last Name: _____ First Name: _____ Middle Initial: ____ Age: _____

Please circle the appropriate numbers.

1. Where is your main problem? _____

2. What is your main problem?

1 Pain
2 Numbness
3 Weakness
4 Stiffness
5 Unstable or Dislocating Joint
6 Swelling
7 Other *(explain):* _____

3. How did your problem start? *(give details as needed)*

1 Job Injury
2 Car Accident
3 Sports Injury
4 Suddenly
5 Gradually
6 Other *(explain):* _____

4. How long have you had this problem, approximately? _____

(give # of days, weeks, months or years)

5. Is your problem:

1 Improving 2 Worsening 3 Staying the Same

6. Does your pain or problem awaken you from sleep? 1 Yes 2 No

7. Is your pain or problem intermittent? 1 Yes 2 No **Constant?** 1 Yes 2 No

8. What worsens your problem? *(give details as needed)*

1 Exercise
2 Sitting
3 Standing
4 Walking
5 Repetitive Motions
6 Overhead Activities
7 Coughing, Sneezing, Straining
8 Rest
9 Nothing
10 Other: _____

9. What helps your problem? *(give details as needed)* 1 Rest 2 Nothing 3 Other *(give details)*_____

10. Are your regular activities limited specifically because of your problem?

1 No 2 Yes *(give details):* _____

11. Have you had this problem before now? 1 No 2 Yes When?_____For how long?_____

12. Have you had previous medical treatment for this? *(give details and general dates)*

1 None
2 Yes
3 Emergency Room_____
4 Physician _____
5 Injection_____
6 Physical Therapy_____
7 Surgery_____
8 Other_____

13. What tests have you had?

1 X-rays
2 CT Scan
3 MRI
4 Nerve Test (EMG)
5 Ultrasound
6 Other:_____

14. What medicines are you taking specifically for this problem? _____

15. Are you on or planning to apply to any of the following programs because of your problem?

A Disability 1 Yes 2 No B Worker's Compensation 1 Yes 2 No

16. What is your occupation? _____

Name:
DOB:
Chart:
Age:
Date:

17. What is your present work status?

1 Not Working — Date last worked _____
2 Light Duty — For how long? _____
3 Regular Job

18. If you are working, does your job require the following?

1 Very Little Lifting (0-10#)
2 Light Lifting (11-20#)
3 Medium Lifting (21-50#)
4 Heavy Lifting (over 50#)
5 Frequent Bending & Lifting
6 Frequent Squatting or Kneeling
7 Climbing
8 Extended Walking
9 Continuous Standing
10 Sitting
11 Repetitive motions with your hands or arms
12 Repetitive motions with your feet or legs

19. Please mark the appropriate box showing how bad your pain or problem is now.

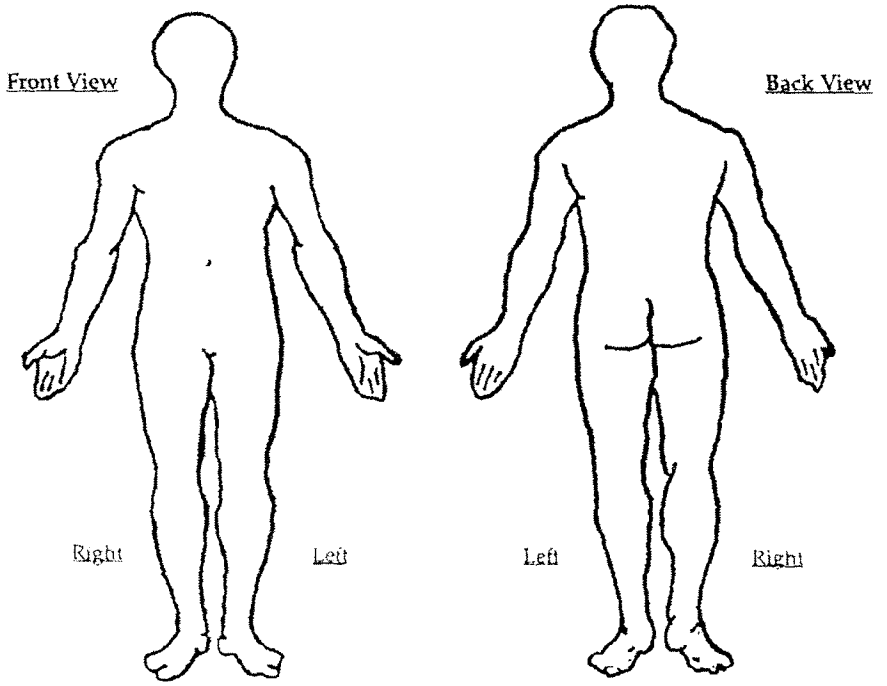
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

No Problem 10 20 30 40 50 60 70 80 90 Worst Problem

20. Where is your pain or problem now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face. Please place an X on the body form where the pain is worst now.

Aching △△△ Numbness ≈≈≈ Pins & Needles ○○○ Burning ⊃⊃⊃ Stabbing ///



21. Please write in any other pertinent details about your problem: _____

_____

_____

22. Are there any other acute problems or crises in your life now?

1 No 2 Yes *(explain)* _____

X _____ _____ X _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN — DATE — DOCTOR'S INITIALS

Name:
DOB:
Chart: Date:
Age:

PLEASE PRINT

TODAY'S DATE 1/8/2016	**PATIENT REGISTRATION**	PT. ID:

PATIENT INFORMATION

LAST NAME				FIRST NAME & INITIAL	Test		
PATIENT SS#		SEX		DATE OF BIRTH			
LANGUAGE		MARITAL STATUS		RACE			
ADDRESS							
CITY				STATE	IN	ZIP	46321
HOME PHONE		WORK PHONE		CELL PHONE		EMAIL ADDRESS	
EMPLOYER		EMLPOYER'S ADDRESS					
OCCUPATION				EMPLOYMENT STATUS	FULL TIME / PART TIME / RETIRED / STUDENT		
SPOUSE'S NAME							
WORK PHONE				SPOUSE'S CELL PHONE			
EMPLOYED	Y / N	EMPLOYER NAME					

RESPONSIBLE PARTY/GUARANTOR

RESP PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
CITY				STATE		ZIP	
SOCIAL SECURITY #				SEX	MALE / FEMALE	DATE OF BIRTH	
RESP PARTY EMPLOYER				EMPLOYER PHONE		EXT.	
EMPLOYER ADDRESS							
HOME PHONE		WORK PHONE		CELL PHONE			

PRIMARY INSURANCE

POLICYHOLDER LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
POLICYHOLDER SS#				SEX	MALE / FEMALE	DATE OF BIRTH	
EMPLOYER				EMPLOYER PHONE		EXT.	
EMPLOYER ADDRESS							

SECONDARY INSURANCE

POLICYHOLDER LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
POLICYHOLDER SS#				SEX	MALE / FEMALE	DATE OF BIRTH	
EMPLOYER				EMPLOYER PHONE		EXT.	
EMPLOYER ADDRESS							

EMERGENCY CONTACT INFO

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU				RELATIONSHIP			
ADDRESS							
HOME PHONE		WORK PHONE		CELL PHONE			

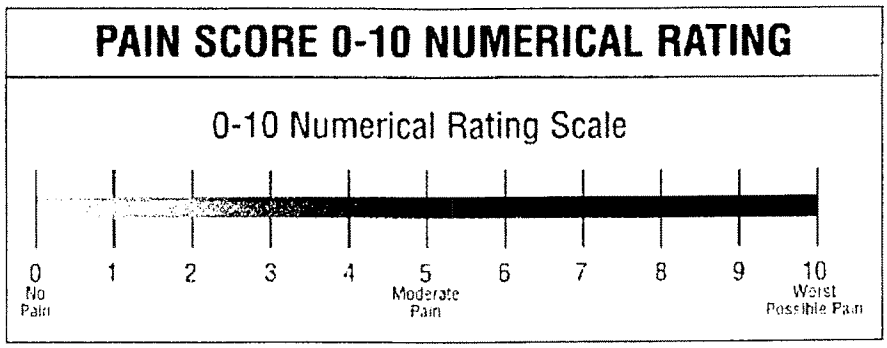
ORTHOPAEDIC SPECIALISTS of Northwest Indiana

Joseph D. Hecht, M.D.
General Orthopaedic Surgery
Nitin Khanna, M.D.
Spine Care Specialist
Jack Gelman, M.D.
Hand & Wrist Surgery

Sunil Dedhia, M.D.
Sports Medicine & Orthopaedic Surgery
Dwight S. Tyndall, M.D.
Spine Care Specialist

Numerical Rating Scale for Pain

Instructions: Circle a number that best indicates how bad your low back pain is at this moment on a scale of 0-10.



Signature of Person Completing: _____

Date of Completion: _____

DATE OF BIRTH: _____

730 45th Street, Munster, Indiana 46321 – (219) 924-3300 / (219) 934-2658 (fax)
www.OSNI.org

Oswestry Disability Index

Instructions: Please review the following questions and choose the one answer for each section that most accurately describes your current abilities or pain.

Section 1 - Pain intensity

- O I have no pain at the moment
- O The pain is very mild at the moment.
- O The pain is moderate at the moment.
- O The pain is fairly severe at the moment.
- O The pain is very severe at the moment.
- O The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- O I can look after myself normally without causing extra pain.
- O I can look after myself normally but it is very painful.
- O It is painful to look after myself and I am slow and careful.
- O I need some help but manage most of my personal care.
- O I need help every day in most aspects of self-care.
- O I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

- O I can lift heavy weights without extra pain.
- O I can lift heavy weights but it gives extra pain.
- O Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- O Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- O I can lift only very light weights.
- O I cannot lift or carry anything at all.

Section 4 - Walking

- O Pain does not prevent my walking any distance.
- O Pain prevents me walking more than one mile.
- O Pain prevents me walking more than a quarter of a mile.
- O Pain prevents me walking more than100 yards.
- O I can only walk using a stick or crutches.
- O I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- O I can sit in any chair as long as I like.
- O I can sit in my favorite chair as long as I like.
- O Pain prevents me sitting more than 1 hour.
- O Pain prevents me from sitting more than half an hour.
- O Pain prevents me from sitting more than 10 minutes.
- O Pain prevents me from sitting at all.

Section 6 - Standing

- O I can stand as long as I want without extra pain.
- O I can stand as long as I want but it gives me extra pain.
- O Pain prevents me from standing for more than 1 hour.
- O Pain prevents me from standing for more than half an hour.
- O Pain prevents me from standing for more than 10 minutes.
- O Pain prevents me from standing at all.

Section 7 - Sleeping

- O My sleep is never disturbed by pain.
- O My sleep is occasionally disturbed by pain
- O Because of pain I have less than 6 hours sleep.
- O Because of pain I have less than 4 hours sleep.
- O Because of pain I have less than 2 hours sleep.
- O Pain prevents me from sleeping at all.

Section 8 - Sex life

- O My sex life is normal and causes no extra pain.
- O My sex life is normal but causes some extra pain.
- O My sex life is nearly normal but is very painful.
- O My sex life is severely restricted by pain.
- O My sex life is nearly absent because of pain.
- O Pain prevents any sex life at all.

Section 9 - Social life

- O My social life is normal and gives me no extra pain.
- O My social life is normal but increases the degree of pain.
- O Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport etc.
- O Pain has restricted my social life and I do not go out as often.
- O Pain has restricted social life to my home.
- O I have no social life because of pain.

Section 10 - Traveling

- O I can travel anywhere without extra pain.
- O I can travel anywhere but it gives me extra pain.
- O Pain is bad but I manage journeys over two hours.
- O Pain restricts me to journeys of less than one hour.
- O Pain restricts me to short necessary journeys under 30 minutes.
- O Pain prevents travel except to receive treatment.

Patient Name (Print):_____

Signature:_____ Date of Completion:_____