NEBRASKA ORTHOPAEDIC CENTER

Date of Visit: _____

Patient #: _____

☐ New Patient ☐ Update

Patient Information

Name: Mr./Mrs./Ms. _____
Last First Middle

Address: _____

Age: _____ Birthdate: _____ Sex: M F Marital Status: Single / Married / Divorced / Widowed

Social Security No: _____ Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Race:
☐ Asian ☐ Black/African American
☐ Caucasian/White ☐ Hispanic
☐ Multi-Racial ☐ Other _____
☐ Decline to Answer

Ethnicity:
☐ Hispanic Origin
☐ non-Hispanic
☐ Decline to Answer

Language:
☐ English
☐ Spanish
☐ Other _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Employer: _____ Occupation: _____

Employer Address: _____

Spouse's Name: _____ Phone: _____

Spouse's Employer: _____

Spouse's Employer Address: _____

Name of Emergency Contact not living with you: _____

Relationship: _____ Primary Phone: _____ Secondary Phone: _____

Who Referred You? _____ Family Doctor: _____

Medical Insurance Information

1) Primary Insurance: _____ Policy Holder Name: _____ DOB: _____

Policy Holder Address: _____ City _____ State Zip _____

Relationship to Insured: _____ Policy ID #: _____ Group #: _____

Policy Holder's Social Security # ---------- _____ Policy Holder's Employer _____

2) Secondary Insurance: _____ Policy Holder Name: _____ DOB: _____

Policy Holder Address: _____ City _____ State Zip _____

Relationship to Insured: _____ Policy ID #: _____ Group #: _____

Policy Holder's Social Security # ---------- _____ Policy Holder's Employer _____

Responsible Party (if patient is a minor)

Name: Mr./Mrs./Ms. _____
Last First Middle

Address: _____

Primary Phone: _____ Secondary Phone: _____

Employer: _____ Relationship to Patient: _____

Personal Health History

NAME_____ HEIGHT_____ WEIGHT_____

Surgeries and Hospitalizations:

Have you had any surgery or hospitalizations?_____Yes_____No **Dominant Hand:** ☐Right ☐Left

If Yes: (Please be specific as to the type of surgery, **body part, right or left**, year and Physician)

___Abdominal Surgery_____ Year_____ Physician_____

___Arthroscopy_____ Year_____ Physician_____

___Arthroscopy_____ Year_____ Physician_____

___Fracture_____ Year_____ Physician_____

___Fracture_____ Year_____ Physician_____

___Heart Surgery/ Procedure_____ Year_____ Physician_____

___Heart Surgery/ Procedure_____ Year_____ Physician_____

___Joint Replacement_____ Year_____ Physician_____

___Joint Replacement_____ Year_____ Physician_____

___Spine Surgery_____ Year_____ Physician_____

___Vascular/ Vein/ Artery_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

Do you have or have you had: (if YES check & explain)

☐ Anemia	☐ Diabetes	☐ Intestinal/ Bowel Problems	☐ Phlebitis
☐ Arthritis	☐ DVT/ Blood Clots	☐ Kidney Problems	☐ Polio
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ Psychological Problems
☐ Birth Defects	☐ Gallbladder Problems	☐ Lung Problems	☐ Pulmonary Embolism
☐ Black Lung Disease	☐ Gout	☐ MRSA/ Staph Infection	☐ Rheumatic Fever
☐ Bladder Problems	☐ Heart Trouble	☐ Neurologic Disorder	☐ Sexually Transmitted Disease
☐ Bleeding Tendency	☐ Hepatitis	☐ Neuropathy	☐ Stroke/ TIA
☐ Blood Transfusion	☐ High Blood Pressure	☐ Osteoporosis	☐ Thyroid Problems
☐ Cancer	☐ High Cholesterol	☐ Pacemaker	☐ Tuberculosis
☐ Cortisone Drug	☐ HIV/ AIDS	☐ Peripheral Vascular Disease	☐ Ulcer (Type_____)
☐ Defibrillator			☐ None of these Apply

Explanation:_____

Do you smoke? ☐ No ☐ Yes If yes, how many packs a day?___Year Started?_____

☐ Former Smoker Year Started?_____Year Quit?_____

Alcohol Use: ☐ No ☐ Yes If yes, please indicate amount and frequency _____

Recreational Drug Use: ☐ No ☐ Yes If yes, what & how often?_____

Please list any additional information you feel would be important to your treatment:

_____

_____

List ALL Medications you are now taking, including herbals and over the counter:

Pharmacy Name & Address

Do you take Aspirin daily? ☐ No ☐ Yes

Do you take a blood thinning medication for ex. Coumadin? ☐ No ☐ Yes

Do you have any allergies to medications? ☐ No ☐ Yes

(If yes, please list them and the reaction you experienced)

Do you have any non-medication allergies? ☐ No ☐ Yes Metal Allergy? ☐ No ☐ Yes

(If yes, please list them & the reaction that you experienced)

Do you have an allergy to LATEX? ☐ No ☐ Yes If yes, please describe your Reaction:

Have you or anyone in your family **(Mother, Father, Sibling or Child)** ever had a reaction to any anesthetic, (general or local), causing malignant hyperthermia (high fever), blood pressure problems, or hepatitis?
If "Yes" Please explain:

Do you know any blood relative (**Mother, Father, Sibling, or Child**) who has or had: (please check & give relationship)

☐ Alzheimer's
☐ Arthritis
☐ Bleeding Tendency
☐ Cancer
☐ Diabetes
☐ Gout
☐ Heart Disease
☐ Kidney Disease
☐ Osteoporosis
☐ Stroke
☐ Sudden Death
☐ Other
☐ *Unknown Family History*

**************PLEASE ANSWER ALL QUESTIONS BELOW REGARDING TODAY'S PROBLEM ONLY*****************

1. What are we seeing you about today?
2. Date of injury, and/or when did you first notice symptoms?
3. What are those symptoms?
4. Where did the injury occur? (Home, work, church, etc.)
5. How did the injury occur?
6. Did you have emergency room treatment? ☐ No ☐ Yes Treated Where?
7. Have you had an x-ray? ☐ No ☐ Yes If yes, where taken?
8. Have you had an MRI, CT ☐ No ☐ Yes If yes, please circle which one and where taken?
9. Have you had a Nerve Test (EMG/NCS)? ☐ No ☐ Yes If yes, by whom?
10. Have you had any Physical Therapy? ☐ No ☐ Yes If Yes, where?
11. Have you had any Cortisone Injections? ☐ No ☐ Yes If Yes, by whom?

Signature: Date:

NOC Account #: _____

Review of Systems: (Please check the following symptoms you have experienced on a regular basis or are being treated for by another provider)

General
- ____ Fever
- ____ Weight change
- ____ Hormonal problems
- ____ Other _____
- ____ **NONE**

Cardiovascular
- ____ Chest Pain
- ____ Palpitations
- ____ Fluid/swelling in extremities
- ____ Pacemaker
- ____ Defibrillator
- ____ Other _____
- ____ **NONE**

Kidney/Bladder
- ____ Painful urination
- ____ Frequent urination
- ____ Incontinence
- ____ Other _____
- ____ **NONE**

Respiratory
- ____ Shortness of breath
- ____ Sleep apnea
- ____ Wheezing
- ____ Other _____
- ____ **NONE**

Eyes
- ____ Glasses/Contacts
- ____ Cataracts
- ____ Glaucoma
- ____ 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**

Hematologic/Lymphatic
- ____ Anemia
- ____ Blood problems
- ____ Clotting disorder
- ____ Lymph problems
- ____ Other _____
- ____ **NONE**

Psychological
- ____ Anxiety
- ____ Depression
- ____ Mood swings
- ____ Other _____
- ____ **NONE**

Neurological
- ____ Headaches
- ____ Numbness
- ____ Tingling
- ____ Seizures
- ____ Weakness
- ____ Other _____
- ____ **NONE**

Skin
- ____ Rashes
- ____ Lumps
- ____ Other _____
- ____ **NONE**

Patient Name: _____ **Date:** _____

Patient/Guardian Signature: _____ **Date:** _____

Provider: _____