SPECIALTY ORTHOPAEDICS, PLLC
PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be confidential. PLEASE PRINT.

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

SOCIAL SECURITY NO: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____ AGE: _____ MALE ____ FEMALE ____

EMPLOYER: _____ OCCUPATION: _____

MOTHER'S FIRST NAME: _____ FATHER'S FIRST NAME: _____

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MEDICAL INSURANCE COMPANY: _____

ADDRESS: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ DOB: _____

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PRIMARY/REFERRING PHYSICIAN: _____

" " ADDRESS: _____

" " PHONE #: _____

REASON FOR SEEING DOCTOR: _____

IN CASE OF EMERGENCY NOTIFY: _____

Whom may we thank for referring you? _____

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***** IF THIS IS NO FAULT OR WORKERS COMPENSATION:

Date of accident/injury: _____ CLAIM/FILE #: _____

INSURANCE CARRIER: _____ ADDRESS: _____

BRIEF DESCRIPTION OF INCIDENT: _____

ARE YOU PRESENTLY WORKING? YES _____ NO _____

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AUTHORIZATION: I hereby give my permission to Specialty Orthopaedics to release any of my (or my child's) medical information to my insurance carrier necessary to process this claim. I accept responsibility for payment of any bills rejected and/or denied by my insurance company. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor.

SIGNATURE-PATIENT OR GUARDIAN: _____ DATE: _____

SPECIALTY ORTHOPAEDICS, LLC
JAMES R. McWILLIAM, MD
INITIAL PATIENT VISIT QUESTIONAIRE

Date:_____ MR# (Office use only)_____

Patient Name: _____

Family/Primary Doctor: _____ Phone: _____

Family/Primary Doctor's Address: _____

Who referred you to Dr. McWilliam?: _____

Age: _____ Sex: _____ Marital Status: _____ Handed: R / L _____

Height: _____ Weight: _____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. ***Circle the word or phrase that best describes your situation. You may select more than one answer per question.*** Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

May we collect your clinical data anonymously for research and outcomes study purposes? Yes / No

Why are your seeing the doctor today?_____

Circle anything listed below to which you are allergic:

(A) No known allergies
(B) Penicillin
(C) Tetracycline
(D) Sulfa
(E) Morphine
(F) Erthromycin
(G) Codeine
(H) Iodine / Betadine
(I) Radiographic dyes
(J) Adhesive Tape
(K) Other (Specify): _____

_____

Circle any of the medical problems that you have had. Indicate if the problem is current or resolved:

(A) I have no known medical problems
(B) Hypertension
(C) Coronary artery disease
(D) Peripheral vascular disease
(E) Adult onset diabetes
(F) Childhood onset diabetes
(G) Past heart attack
(H) Asthma
(I) Ulcers
(J) Hepatitis A/B/C
(K) Cancer
(L) Blood clot (DVT)
(M) Tuberculosis
(N) Liver disease
(O) Seizure disorder
(P) Thyroid disease
(Q) Emphysema
(R) COPD/ Lung problem
(S) Immune disorder
(T) Overweight
(U) Osteomyelitis
(V) Arthritis (where?):
(W) Other (Specify): _____

_____

How much alcohol do you consume?

(A) I'm a non-drinker
(B) I'm a recovering alcoholic
(C) I drink only occasionally
(D) I drink weekends only
(E) An average of 1-2 drinks per day
(F) An average of 2-3 drinks per day
(G) An average of 3-5 drinks per day
(H) More than 6 drinks per day

Do you now, or have you ever smoked cigarettes?

(A) Yes, I am currently a smoker
I smoke (circle one) 1 2 3 _____ packs/day
I have smoked for _____ years
(B) No, but I used to smoke I smoked for _____ years 1 2 3 _____packs/day
(C) No, I have never smoked

Do you now, or have you ever used drugs?
(A) Recreational (B) Marijuana (C) Cocaine (D) Other (Specify): _____

Has anyone in your immediate family (mother, father, sister, brother, children) ever had any of the following? Circle all that apply.

(A) None known
(B) Cancer
(C) Leukemia
(D) Stroke
(E) Hypertension
(F) Coronary artery disease
(G) Rheumatic fever
(H) Diabetes
(I) Hypothyroidism
(J) Colitis
(K) Bleeding tendency
(L) Asthma
(M) Tuberculosis
(N) Seizure disorder
(O) Alcoholism
(P) Other (Specify): _____

Have you ever had a blood clot? Yes No

Circle any surgeries below that you may have had. Indicate the year of the surgery:

(A) No previous surgeries
(B) Appendectomy _____
(C) Cataract extraction _____
(D) By-pass/ open heart _____
(E) Gall bladder _____
(F) Hernia repair _____
(G) Hysterectomy _____
(H) Lumbar laminectomy _____
(I) Mastectomy _____
(J) Tonsillectomy _____
(K) Prostate surgery _____
(L) Other (Specify): _____

Blood transfusion? (Circle one) **Yes / No** Year: _____

What medications are you currently taking? Please include any vitamins, tonics, muscle relaxants, anti-inflammatories, pain relievers, nerve medications, and sleeping pills you are taking, both prescription and non-prescription.

Medication	Dose	Number of times per day

Please circle any anti-inflammatory or analgesic medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

Advil Arthrotec Daypro Ibuprofen Lodine Naprelan Naproxen Oruvail
Tylenol Ultram Celebrex Vioxx Other: _____

Please circle any of the following side effects you experienced while you were taking any of the above anti-inflammatory or analgesic medications.

Nausea Diarrhea Gastric Ulcers Upset stomach Vomiting
Other: _____

Are you currently taking any of the following on a regular basis?

Aspirin Axid Coumadin Cytotec Heparin Maalox Mylanta
Prevacid Prilosec Tagamet Zantac Pepcid

Tell us about your health in general: Do you have any of the following symptoms?

Chest pain	Yes	No	Abdominal cramping	Yes	No
Dizziness	Yes	No	Varicose veins	Yes	No
Dry cough	Yes	No	Bruising	Yes	No
Productive cough	Yes	No	Bleeding	Yes	No
Difficulty breathing	Yes	No	Nose bleeds	Yes	No
Irregular heartbeat	Yes	No	Joint pain/stiffness	Yes	No
Swelling in the legs	Yes	No	Muscle pain/cramps	Yes	No
Lack of appetite	Yes	No	Difficulty seeing	Yes	No
Nausea	Yes	No	Difficulty hearing	Yes	No
Vomiting	Yes	No	Difficulty swallowing	Yes	No
Diarrhea	Yes	No	Difficulty sleeping	Yes	No
Constipation	Yes	No			

What is your current occupation?

(A) Student
(B) Housewife
(C) Retired (from what occupation? _____ since when? _____

(D) Employed ____ Full time ____ Part time as _____
(E) Currently unemployed
(F) Disability? ___Permanent ____ Partial Since (date) _____ due to _____
(G) Comments: _____

Do you live:

(A) Alone
(B) With family
(C) With friends
(D) Other (Specify) _____

The doctor will discuss your current problem with you in detail. The following questions are intended to give an overview of how it is affecting you now. Please select the best choice for each item.

Do you have pain:
(A) None
(B) Mild, occasional
(C) Moderate, daily
(D) Severe, almost always present

What is your activity level?
(A) No limitations, no support
(B) No limitation of daily activities, limitation of recreational activities, no support
(C) Limited daily and recreational activities, cane
(D) Severe limitation of daily and recreational activities, walker, crutches, wheelchair, brace

Footwear requirements:
(A) Fashionable, conventional shoes, no insert required
(B) Comfort footwear and/or shoe insert
(C) Modified shoes or brace

Maximum walking distance:
(A) Greater than 6 blocks
(B) 4-6 blocks
(C) 1-3 blocks
(D) Less than 1 block

Walking surfaces:
(A) No difficulty on any surfaces
(B) Some difficulty on uneven terrain, stairs, inclines, ladders
(C) Severe difficulty on uneven terrain, stairs, inclines, ladders

Everything I have answered is true and correct to the best of my knowledge. _____
Patient Signature

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
IT WILL BECOME PART OF YOUR PERMANENT MEDICAL RECORD AT
SPECIALTY ORTHOPAEDICS. IT WILL PLAY AN IMPORTANT
PART IN UNDERSTANDING YOUR CURRENT SITUATION, AND FOLLOWING YOU IN THE FUTURE.

SPECIALTY ORTHOPAEDICS, PLLC
Steven B. Zelicof, M.D., Ph.D.
Associate Professor of Clinical Orthopaedic Surgery
New York Medical College

Sound Shore

Chief, Orthopaedic Surgery
Sound Shore Medical Center of Westchester

Chief, Joint Reconstruction Service
Westchester Medical Center

This notice describes how medical information about you may be used and disclosed by this office and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice.
We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.
We will post a copy of the current notice in the office.

The notice will contain on all the pages, in the bottom left hand corner, the effective date.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact Sonia Farina, Privacy Officer, at 914-686-0111. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION:
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I acknowledge receipt of a copy of Specialty Orthopaedics' Notice of Privacy Practices.

_____
Patient Name (Please print)

_____
Parent or Authorized Representative (if applicable)

_____ _____
Signature Date

Effective Date: 4/14/03

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