# Patient Information Record

(PLEASE PRINT)

Patient Name: _____
Last First Middle

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ ext. _____ Cell Phone: (___) _____

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Email address (for appointment purposes only): _____@_____ . COM

Social Security #: _____-_____-_____ Driver's License: _____ State: _____

Employer Name or School: _____ Occupation: _____

Spouse/Parent Name: _____ Home Phone: (___) _____ Work Phone: (___) _____

## Insurance Policy Holder

Name of Policy Holder: _____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Phone Number : (___) _____

Insurance Company & Address: _____

Policy Number: _____ Group Number: _____ Insurance Phone #: (___) _____

Employer Name & Address: _____

**Patients are responsible for full payment at time of visit.**

## Nearest Relative or Friend in Case of Emergency

Name: _____ Home Phone: (___) _____ Work Phone: (___) _____

City: _____ Relationship to Patient: _____

Name: _____ Home Phone: (___) _____ Work Phone: (___) _____

City: _____ Relationship to Patient: _____

**MEDICAL CARE:** I authorize William C. Nemeth, M.D., P.A. or their designees to provide myself or my child with reasonable and proper medical care according to today's standards.

**MEDICAL INFORMATION:** I authorize William C. Nemeth, M.D., P.A. to release any information they have acquired in the course of my treatment or my child's treatment to my insurance company or companies or any third-party payor as necessary to obtain payment for medical services rendered.

**INSURANCE AUTHORIZATION:** I hereby authorize William C. Nemeth, M.D., P.A. or staff to furnish information to my insurance carriers concerning myself or my child's illness or treatments.

**ASSIGNMENT OF BENEFITS:** I authorize the insurance company or any third-party payor to pay any benefits due directly to William C. Nemeth, M.D., P.A. should they accept assignment on my claim. **I agree that I am financially responsible for the full payment of my account.**

_____ _____

Signature of Patient or Parent/Guardian Date

# Patient Health History

Name: _____ Date of Birth: ____/____/____

**Past Medical History:**

*Check all items that apply to you. Comment in space provided below.*

☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Birth Defects
☐ Blood Transfusions
☐ Cancer/Tumor
☐ Chicken Pox
☐ Colon Disease
☐ COPD/Emphysema/Lung Disease
☐ Diabetes
☐ Drug or Alcohol Abuse
☐ Epilepsy/Seizures
☐ Glaucoma or Cataracts
☐ Headaches
☐ Hearing Loss
☐ Heart Disease
☐ Hepatitis/Jaundice
☐ HIV/AIDS
☐ Hypertension
☐ Hypo– or Hyper-thyroid
☐ Kidney Disease/Stones
☐ Mental Illness/Depression
☐ Pap Smear - Abnormal
☐ Peptic Ulcer Disease
☐ Sexually Transmitted Disease (STD)
☐ Sickle Cell Anemia or Trait
☐ Skin Disease/Eczema/Psoriasis
☐ Stroke
☐ Tuberculosis
☐ Other: _____
☐ Other: _____
☐ Other: _____

**Comments:**

**Past Surgical or Hospitalization History:**

☐ Angioplasty
☐ Appendectomy
☐ Back Procedure
☐ Breast Procedure
☐ Cervical Freezing or LEEP
☐ Fracture
☐ Gall Bladder
☐ Hernia
☐ Hysterectomy ☐ Ovaries Removed
☐ Knee Procedure
☐ Psychiatric Hospitalization
☐ Tonsillectomy
☐ Tubal Ligation
☐ Vasectomy
☐ Other: _____
☐ Other: _____

**Comments:**

**Health Maintenance:**

Date of last: Physical Exam _____ Colon Cancer Screening _____ X-Ray/MRI _____

**Female Only:**

Age at 1st Period: _____ Birth Control Method: _____

Number of: Pregnancies _____ Children _____ Miscarriages _____

Date of last Period: _____ Pap Smear _____ Mammogram _____

**Male Only:**

Date of last: Prostrate Exam _____ PSA _____

Name: _____ Date of Birth: ____/____/____

**Drug Allergies:** ☐ No Known Drug Allergies

| Name of Drug | Reaction |
|---|---|
| | |
| | |

**Current Medications (use separate page if needed):**

| Medication | Dose | Reason |
|---|---|---|
| | | |
| | | |
| | | |

**Immunizations (Year Received):**

☐ Tetanus Booster _____ ☐ Influenza Vaccine _____ ☐ TB Skin Test _____

☐ Pneumovax _____ ☐ Hepatitis B _____ ☐ Other: _____

**Social History:**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Highest Level of Education: _____

Tobacco: ☐ None ☐ Cigarettes (packs per day) _____ ☐ Other _____ ☐ Quit (Year) _____

Alcohol: ☐ None ☐ Drink per week _____

Caffeine: ☐ None ☐ Cups per day _____

Exercise: ☐ None ☐ How often? _____

Sexually Active: ☐ Yes ☐ No Explain?: _____

Victim of Abuse: ☐ Verbal ☐ Mental ☐ Physical ☐ Sexual ☐ Current?

Use Seat Belts: ☐ Yes ☐ No Explain?: _____

Exposure to Hazardous Materials?: ☐ Yes ☐ No Explain?: _____

Military Service?: ☐ Yes ☐ No Explain?: _____

Special Diet or Vegetarian?: ☐ Yes ☐ No Explain?: _____

Travel to Foreign Countries?: ☐ Yes ☐ No Explain?: _____

**Family History:**

| Relative | Living | Deceased | Age/Age at Death | Health Status/Cause of Death |
|---|---|---|---|---|
| Father | ☐ | ☐ | | |
| Mother | ☐ | ☐ | | |
| Sibling | ☐ | ☐ | | |
| Sibling | ☐ | ☐ | | |
| Sibling | ☐ | ☐ | | |
| Sibling | ☐ | ☐ | | |
| Child | ☐ | ☐ | | |
| Child | ☐ | ☐ | | |

_____ _____

Signature of Patient or Parent/Guardian Date

## Lower Limb Outcome Scale

**Name** _____ **Date** _____

**Instructions:** These questions ask your views about your lower limb (leg)/Lower Back. Please answer every question, based on your condition in the last week, by **circling** the appropriate number.

| | *Not at All* | *Mildly* | *Moderately* | *Very* | *Extremely* |
|---|---|---|---|---|---|
| 1. During the past week, how stiff was your lower limb? | *1* | *2* | *3* | *4* | *5* |
| 2. During the past week, how swollen was your lower limb? | *1* | *2* | *3* | *4* | *5* |

| | *Not Painful* | *Mildly Painful* | *Moderately Painful* | *Very Painful* | *Extremely Painful* | *Could not do because of pain* | *Could not do because of Other* |
|---|---|---|---|---|---|---|---|
| 3.. Walking on flat surfaces? | *1* | *2* | *3* | *4* | *5* | *6* | *7* |
| 4. Going up or down stairs? | *1* | *2* | *3* | *4* | *5* | *6* | *7* |
| 5. Lying in bed at night? | *1* | *2* | *3* | *4* | *5* | *6* | *7* |

| | *Did not need support* | *Mostly walked without support* | *Mostly used 1cane / crutch* | *Mostly used 2 canes / crutches* | *Used a wheelchair* | *Mostly used other supports / someone* | *Unable to get around* |
|---|---|---|---|---|---|---|---|
| 6. Which statements best describes your ability to get around most of the time during the **past week**? | 1 | *2* | *3* | *4* | *5* | *6* | *7* |

| | *Not at All* | *Mildly* | *Moderately* | *Very* | *Extremely* | *Cannot do it at all* |
|---|---|---|---|---|---|---|
| 7. How difficult was it for you to put on or take off socks/stockings during the **past week**? | *1* | *2* | *3* | *4* | *5* | *6* |

# ACTIVITIES OF DAILY LIVING QUESTIONNAIRE

Name: _____ Date: _____

| Activity Perform | No Difficulty | Some Difficulty | Cannot |
|---|---|---|---|
| **Self Care, Personal Hygiene** | | | |
| Urinating | | | |
| Defecating (Bowel Movement) | | | |
| Brushing Teeth | | | |
| Combing Hair | | | |
| Bathing | | | |
| Dressing | | | |
| Eating | | | |
| **Communication** | | | |
| Writing | | | |
| Typing | | | |
| Seeing | | | |
| Hearing | | | |
| Speaking | | | |
| **Physical Activity** | | | |
| Standing | | | |
| Sitting | | | |
| Reclining | | | |
| Walking | | | |
| Climbing Stairs | | | |
| **Sensory Function** | | | |
| Hearing | | | |
| Seeing | | | |
| Tactile Feeling (Touch) | | | |
| Tasting | | | |
| Smelling | | | |
| **Nonspeciialized Hand Activity** | | | |
| Grasping | | | |
| Lifting | | | |
| Tactile Discrimination | | | |
| **Sexual Function** | | | |
| Orgasm | | | |
| Ejaculation | | | |
| Lubrication | | | |
| Erection | | | |
| **Sleep, Restful Pattern** | | | |

# Quick Dash

**Name:** _____ **Date:** _____

Instructions: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer every question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week by **circling** the number below the appropriate response.

| | *No Difficulty* | *Mild Difficulty* | *Moderate Difficulty* | *Severe Difficulty* | *Unable* |
|---|---|---|---|---|---|
| 1. Open a tight or new jar. | *1* | *2* | *3* | *4* | *5* |
| 2. Do heavy household chores (e.g., wash walls, floors). | *1* | *2* | *3* | *4* | *5* |
| 3. Carry a shopping bag or briefcase. | 1 | *2* | *3* | *4* | *5* |
| 4. Wash your back. | *1* | *2* | *3* | *4* | *5* |
| 5. Use a knife to cut food. | *1* | *2* | *3* | *4* | *5* |
| 6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.). | *1* | *2* | *3* | *4* | *5* |

| | *Not at All* | *Slightly* | *Moderately* | *Quite A Bit* | *Extremely* |
|---|---|---|---|---|---|
| 7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? | *1* | *2* | *3* | *4* | *5* |

| | *Not Limited At all* | *Slightly Limited* | *Moderately Limited* | *Very Limited* | *Unable* |
|---|---|---|---|---|---|
| 8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? | *1* | *2* | *3* | *4* | *5* |

| Please rate the severity of the following symptoms in the last week. | *None* | *Mild* | *Moderate* | *Severe* | *Extreme* |
|---|---|---|---|---|---|
| 9. Arm, shoulder or hand pain. | *1* | *2* | *3* | *4* | *5* |
| 10. Tingling (pins and needles) in your arm, shoulder or hand. | *1* | *2* | *3* | *4* | *5* |

| | *No Difficulty* | *Mild Difficulty* | *Moderate Difficulty* | *Severe Difficulty* | *So Much Difficulty That I Can't Sleep* |
|---|---|---|---|---|---|
| 11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? | *1* | *2* | *3* | *4* | *5* |

# Opioid Risk Tool (ORT)

## Patient Form

**Name** _____ **Date** _____

| Mark each box that applies | | Female | Male |
|---|---|---|---|
| 1. Family history of substance abuse | ■ Alcohol<br>■ Illegal drugs<br>■ Prescription drugs | [ ]<br>[ ]<br>[ ] | [ ]<br>[ ]<br>[ ] |
| 2. Personal history of substance abuse | ■ Alcohol<br>■ Illegal drugs<br>■ Prescription drugs | [ ]<br>[ ]<br>[ ] | [ ]<br>[ ]<br>[ ] |
| 3. Age (mark box if 16-45 years) | | [ ] | [ ] |
| 4. History of preadolescent sexual abuse | | [ ] | [ ] |
| 5. Psychological disease | ■ Attention-deficit/ hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia<br>■ Depression | [ ]<br>[ ] | [ ]<br>[ ] |