LIST OF MEDICATIONS FOR PATIENT:____

**List All medications: Also any Herbal, Vitamins or Over the Counter Meds.						
MEDICATION NAME	DOSAGE	FREQ.	DOCTOR	DATE PRESCRIBED	ROUTE	INDICATION

REVIEW OF SYSTEMS

Your name____ **Date**__________________

For each of the items listed below, please place a check mark in the **YES** column if you are experiencing the symptom or place a check mark in the **NO** column if you have not experienced the symptom. We appreciate your help in giving this information.

	YES	NO
EYES/VISION		
Loss or change of vision		
Double or blurred vision		
EARS/HEARING		
Loss of hearing		
Buzzing or noise in ear		
NOSE AND THROAT		
Hoarseness		
Nose bleeds		
Difficulty swallowing		
BREATHING/RESPIRATORY		
Shortness of breath		
Excessive cough		
Night sweats		
Fevers		
NEUROLOGICAL		
Frequent headaches		
Dizziness or fainting spells		
Seizures or convulsions		
Memory loss		
HEART/CARDIOVASCULAR		
Chest pain		
Abnormal heartbeat		
STOMACH AND INTESTINES		
Frequent nausea or vomiting		
Recent weight loss		
Stomach, abdominal, bowel pain		
Frequent or severe constipation		
URINARY		
Bloody urine		
Painful or difficulty in urination		
Frequent urination		
MUSCLES AND SKELETAL		
Joint swelling		
Joint pain		
Loss of motion in joints		
Swelling of extremities		
SKIN		
Rashes		
Expanding moles		

Name of cardiologist (if you visit one) ____

601 TEXAN TRAIL, SUITE 300, CORPUS CHRISTI, TEXAS 7841
TELEPHONE: (361)854-0811 FAX: (361)806-504(

www.SouthTexasBoneandJoint.com

Sports Medicine

Charles W. Breckenridge, M.D.
Arthroscopy & Shoulder Surgery

Bernard M. Seger, M.D.
Arthroscopy & Knee Surgery

Lauren A. Vesely, P.A.-C

Adult Spinal Surgery

John P. Masciale, M.D.

John M. Borkowski, M.D.

Stephen Springer, P.A.-C

Foot and Ankle Surgery

Dawn M. Grosser, M.D.

Surgery of the Hand

Ryan B. Thomas, M.D.

Jose R. Recio, P.A.-C

Joint Reconstruction
Joint Replacement
Arthritis Surgery

Justin Klimisch, M.D.

Christian P. Ehrhard, P.A.-C

General Orthopaedics

Frank A. Luckay, M.D.

Primary Care
Sports Medicine

Michael W. Montgomery, M.D.

Orthopaedic Nurse Practitioner

Kaylene John, MSN, APRN FNP-C

ACCIDENT/SYMPTOM INFORMATION

PATIENT NAME: ______________________________________
(Please print)

IF YOUR OFFICE VISIT TODAY IS THE RESULT OF AN ACCIDENT

PLEASE COMPLETE THE FOLLOWING INFORMATION.

IS THIS WORK RELATED?

YES_______ NO_______

DESCRIBE HOW YOU WERE INJURED: ______________________

____

DATE OF INJURY: ___________________________________

WHERE THE ACCIDENT HAPPENED: ______________________

____

IF THIS WAS NOT AN ACCIDENT, PLEASE GIVE US THE FIRST DATE OF YOUR SYMPTOMS APPEARED ON THE SPACE BELOW.

DATE: ____

__________________________ ______________________
SIGNATURE (parent if minor) DATE

South Texas Bone and Joint

John Borkowski, M.D.

Patient Name:______________________________ Age:_____ Sex:_____ Date:__________

Occupation:________________________________ Date of Injury:______________________

INJURY:

*How were you injured:____

*Are you still working? **Y** or **N**

*What happened directly after your injury? Instant pain / left work
Kept working

*Past back injuries:____

PAIN: Stabbing / dull ache / burning / pins & needles / sharp / numbness

*Back pain (Upper / Middle / Lower) or Leg pain (Left or Right)
Which is worse?

*Neck pain or arm pain (which arm is worse Left or Right)

*Location of Radiating pain to extremities:
Foot: Great toe/ 2nd toe / 3rd toe / 4th toe / pinky toe / top or bottom
Hand: Thumb / Index / Middle / Ring / pinky / top or bottom
Leg: Calf / Thigh

*What increases your pain? Sitting / Lying
Walking – How far can you walk:_____________________________________
Sneezing / coughing / overhead activities

*What makes your pain better? ____

*Scale 1 –10 (10 being the highest of pain) How bad is your pain?____________
Is your pain getting better or worse? ____________________________________

TREATMENT:

*What type of treatment have you had?___________________________________
Physical Therapy:__________________________ Treatment________________
Chiropractor:_____________________________ Treatment________________
Injections: Y or N If yes how many ______________ Doctor:_____________

*Any past history of spine pain?______________________________________

*Spinal surgeries?____

*Any incontinence of Bladder or Bowel?_______________________________

*Allergies:____

Past Medical History:	Social:	Medication:
______________________	_______________	______________
______________________	_______________	______________
______________________	_______________	______________

PHYSICAL EXAM

NEURO: **SENSORY:** **EXTREMITY:**

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ________________________, understand that as part of my health care, SOUTH TEXAS BONE & JOINT originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that SOUTH TEXAS BONE & JOINT is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that SOUTH TEXAS BONE & JOINT reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should SOUTH TEXAS BONE & JOINT change their notice, they will send a copy of my revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept the terms of this consent.

____
Patient's Signature

____
Date

FOR OFFICE USE ONLY
[ ] Consent received by ______________________________ on ____________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on ___________________________.