Dear Patient,

Welcome to Beacon Orthopaedics and Sports Medicine! Your appointment is confirmed for ___________________________at______________ am/pm with Dr.________________________.

Please complete the enclosed registration and history forms. Please bring the completed forms with you to your appointment. If you have had any x-rays taken or other testing done prior to your visit, please bring those as well.

We also require a picture ID and insurance cards at the time of your appointment. If your insurance carrier requires a referral, please contact your primary care physician immediately. We need to receive the referral authorization prior to your visit.

If this is a work related injury, we will require the following information:

- Employer's name, phone number, and contact person
- First Report of Injury
- Name and address of MCO
- Claim Number
- Date of Injury

Please refer to the highlighted address on the left side of this letter for the location of your office visit.

We look forward to serving you.

Beacon Orthopaedics & Sports Medicine **New Patient Questionnaire**

Dear Patient,

The following are important steps that must be taken to help us address your clinical concerns in the most comprehensive and efficient manner possible.

1. Registration: You should have already completed the registration process when you scheduled your appointment. If you have made any changes such as address, phone number, etc., or need to cancel or change your appointment, please call (513) 346-1500 option 2.

2. Questionnaire: We have found it most helpful to have an orderly, written depiction of our patient's complaints, testing, and other related medical conditions prior to initiating our evaluations. Please complete the enclosed questionnaire and bring it with you on the day of your appointment. Failure to do so will result in your appointment being rescheduled.

3. Prior Testing: For your evaluation to be complete, it is necessary for you to bring all prior testing pertaining to the problems for which you are being seen. This includes the *ACTUAL* films or CD of the images, as well as written reports and any other testing information associated with your current clinical concern.

4. Insurance: Some insurance plans require a referral from your primary care doctor. It is your responsibility to obtain this referral, if required, or to assume responsibility for services that may not be paid without such a referral. You must also sign the "Patient Consent and Financial Responsibility" form outlining our financial policies. Pain Medication: In most cases, we ask that your family doctor or current prescribing physician continue to manage your medication needs unless it is determined that you are in need of surgical intervention. In that instance, medication management may be temporarily assumed by the surgeon handling your case. In the event that pain medication is managed in this office, you will be required to sign a "Chronic Pain Medication Treatment Agreement".

Thank you for taking the time to comply with the above requests.

As a reminder please bring:

Co-pay (if required by your insurance company)
Driver's License
Insurance Card
Completed New Patient Packet
A list of all medications you are currently taking
ALL PRIOR OFFICE NOTES
ALL PRIOR TESTS
ALL PRIOR LABS
ALL IMAGING REPORTS AND IMAGES ON CD. (Ex. MRI, CT, Discogram)

All of the above items must be presents at your appointment. Failure to do so will result in your appointment being rescheduled.

Your appointment with ☐ Dr. Borden ☐ Stephanie Sobol, CNP

is on ____________________ at ___________________ am / pm at

☐ Anderson - Five Mile, 7794 Five Mile Road, Cincinnati, Ohio 45230

☐ Kenwood, 8311 Montgomery Road, Cincinnati, Ohio 45236

☐ Liberty, 8020 Liberty Way, West Chester, Ohio 45069

☐ Montgomery, 8099 Cornell Road, Suite 100, Cincinnati, Ohio 45249

Patient Name: ______________________________ Date of Birth: ____________

Gender: ☐ MALE ☐ FEMALE Are you ☐ RIGHT HANDED ☐ LEFT HANDED

Address: ____

Home Phone: ______________ Cell: ________________ Work: ________________

Referring Physician Name: ______________________________

Address: ____

Phone Number: ______________________________

Primary Care Physician Name: ______________________________

Address: ____

Phone Number: ______________________________

HISTORY OF ILLNESS / REASON FOR OFFICE VISIT

Describe the symptoms you are experiencing ______________________________

____

How did your symptoms begin? ______________________________

____

The symptoms started on (give specific date, if known) ______________________________

Since your symptoms began, they have gotten ☐ Better ☐ Worse ☐ No Change

Name any other physicians who have treated you for this problem:

PHYSICIAN'S NAME	TYPE OF PHYSICIAN	MONTH/YEAR
1)		
2)		
3)		

HAVE YOU HAD ANY OF THE FOLLOWING TREATMENT(S) FOR THIS ILLNESS OR INJURY?
(CHECK ALL THAT APPLY)

☐ NONE ☐ TRACTION ☐ EPIDURAL STEROID INJECTION ☐ ICE
☐ CHIROPRACTIC MANIPULATION ☐ ULTRASOUND ☐ HOT PACKS
☐ ELECTRICAL STIMULATION ☐ PAIN MANAGEMENT PHYSICIAN
☐ PHYSICAL THERAPY FOR THIS CONDITION?
If yes, where and when (MONTH/YEAR) ______________________________
☐ MEDICATION
What medications have or are you taking now for this condition? ______________________________

____

Beacon Orthopaedics & Sports Medicine **New Patient Questionnaire**

Patient Name: ________________________ DATE OF BIRTH: ____________

DIAGNOSTIC TESTS

Have you had any of the following diagnostic tests for the illness or injury?

HAVE YOU HAD ANY OF THE FOLLOWING DIAGNOSTIC TESTS FOR THIS ILLNESS OR INJURY?

	Where was the test done	Dates
☐ PLAIN SPINE X-RAYS	____________	____________
☐ MRI SCAN	____________	____________
☐ CT SCAN	____________	____________
☐ MYELOGRAM/CT SCAN	____________	____________
☐ EMG/NERVE CONDUCTION	____________	____________
☐ BONE SCAN	____________	____________
☐ OTHER	____________	____________

MEDICAL HISTORY OF PATIENT

HAVE YOU EVER BEEN DIAGNOSED WITH?

☐ DIABETES CONTROLLED BY: ☐ INSULIN ☐ DIET ☐ ORAL AGENTS ☐ BLOOD CLOTS
☐ HYPERTENSION ☐ GOUT ☐ ASTHMA
☐ HEART DISEASE ☐ HEART ATTACK (MI) ☐ ANGINA (CHEST PAIN)
☐ STROKE ☐ SEIZURES/CONVULSIONS ☐ THYROID PROBLEMS
☐ TUBERCULOSIS ☐ DEPRESSION ☐ ANXIETY
☐ ACUTE INFECTION ☐ EMPHYSEMA/COPD ☐ HIV/AIDS
☐ ARTHRITIS ☐ REFLUX DISEASE (GERD) ☐ VENEREAL DISEASE
☐ HEREDITARY DEFECTS ☐ BLEEDING TENDENCY ☐ CONGESTIVE HEART FAILURE
☐ CANCER (TYPE & TREATMENT) ________________________
☐ HISTORY OF HEART ATTACK OR HEART DISEASE ________________________
IF YES, CARDIOLOGIST NAME PHONE ADDRESS ________________________
☐ OTHER ________________________

SURGICAL HISTORY - List all types of surgery and the year you had the surgery.

____

____

____

MEDICATION HISTORY

LIST ALL YOUR MEDICATION(S) (PRESCRIPTION, OVER-THE-COUNTER, HERBAL)
NAME AMOUNT NUMBER PER DAY NAME AMOUNT NUMBER PER DAY

____________ ____________
____________ ____________
____________ ____________
____________ ____________
____________ ____________

DO YOU TAKE BLOOD THINNERS? ☐ ASPRIN ☐ COUMADIN ☐ PLAVIX ☐ OTHER
DO YOU HAVE ANY ALLERGIES?
☐ NO KNOWN ☐ PENICILLIN ☐ SULFA ☐ DEMEROL ☐ MORPHINE
☐ LATEX ☐ CONTRAST DYE ☐ IODINE ☐ TAPE ☐ SHELLFISH

☐ OTHER ____

Patient Name: ______________________________ DATE OF BIRTH:____________

HAVE YOU BEEN TREATED FOR BLOOD CLOTS? ☐ YES ☐ NO

HAVE YOU BEEN TREATED FOR EXCESSIVE BLEEDING? ☐ YES ☐ NO

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ YES ☐ NO

IS THERE ANY REASON YOU CANNOT RECEIVE A BLOOD TRANSFUSION? ☐ YES ☐ NO
IF YES, EXPLAIN ____

HAVE YOU EVER BEEN SERIOUSLY INJURED? ☐ YES ☐ NO INJURY DATE ____/____/____
IF YES, EXPLAIN ____

HAVE YOU BEEN HOSPITALIZED IN THE PAST YEAR? ☐ YES ☐ NO
IF YES, EXPLAIN ____

HAVE YOU EVER HAD AN INFECTION CALLED MRSA? ☐ YES ☐ NO
IF YES, WAS IT TREATED WITH ANTIBIOTICS? ______________________________

FAMILY MEDICAL HISTORY

HAVE YOUR PARENTS OR SIBLINGS (BROTHERS/SISTERS) EVER BEEN DIAGNOSED WITH?

☐ HEART DISEASE
☐ CANCER
☐ HIGH BLOOD PRESSURE
☐ LUNG PROBLEMS
☐ ALZHEIMER'S/MEMORY PROBLEMS
☐ DIABETES
☐ KIDNEY DISEASE
☐ BRAIN TUMOR
☐ MULTIPLE SCLEROSIS
☐ OTHER ______________________
☐ STROKE
☐ DEPRESSION
☐ ANEURYSM
☐ PARKINSON'S DISEASE

MOTHER: ☐ LIVING ☐ DECEASED AGE _____ CAUSE OF DEATH ____________
FATHER: ☐ LIVING ☐ DECEASED AGE _____ CAUSE OF DEATH ____________
SIBLING(S): # ALIVE # DECEASED AGE(S) CAUSE OF DEATH

SOCIAL HISTORY

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DO YOU LIVE ALONE? ☐ YES ☐ NO

DO YOU HAVE ANY CHILDREN? ☐ YES ☐ NO
IF YES, LIST THE AGE(S) AND IF THEY LIVE AT YOUR HOME ______________________

DO YOU NOW USE ANY TOBACCO PRODUCTS? ☐ YES ☐ NO
IF YES, SPECIFY ☐ CIGARETTES ☐ SNUFF TOBACCO ☐ CIGARS ☐ PIPE
HOW MUCH /DAY ____________ FOR HOW MANY YEARS? ______________________

DID YOU USE ANY TOBACCO PRODUCTS IN THE PAST? ☐ YES ☐ NO
IF YES, FOR HOW LONG ________ HOW MUCH/DAY ________ WHEN DID YOU QUIT?__________

DO YOU DRINK ALCOHOL?
☐ YES ☐ NEVER ☐ NOT CURRENTLY, BUT USED TO DRINK ________ DRINKS A WEEK
IF YES, SPECIFY ☐ BEER ☐ WINE ☐ LIQUOR AMOUNT PER WEEK
FOR HOW MANY YEARS? __________ WHEN DID YOU QUIT? ____________________

DO YOU USE ANY RECREATIONAL DRUGS? ☐ YES ☐ NO
IF YES, SPECIFY ☐ MARIJUANA ☐ COCAINE/CRACK ☐ SPEED ☐ HALLUCINOGENS ☐ NARCOTICS
FOR HOW MANY YEARS? ________ WHEN DID YOU QUIT? ________ DATE LAST USED ________

Patient Name: ______________________________________ DATE OF BIRTH:____________

WORK HISTORY

HIGHEST LEVEL OF EDUCATION: ☐ GRADE SCHOOL ☐ HIGH SCHOOL ☐ COLLEGE ☐ POST GRADUATE

WORK STATUS: ☐ EMPLOYED ☐ UNEMPLOYED ☐ DISABLED ☐ RETIRED

DO YOU WORK OUTSIDE THE HOME? ☐ YES ☐ NO

EMPLOYER ____________________ LENGTH OF EMPLOYMENT ______________________

JOB TITLE _____________________ HOW LONG HAVE YOU PERFORMED THIS JOB? ________

DID A PHYSICIAN PLACE YOU OFF WORK? ☐ YES ☐ NO
IF NO, ARE YOU CURRENTLY WORKING WITH THESE SYMPTOMS? ☐ YES ☐ NO
IF YES, WHEN DID YOU STOP WORKING? ____

DOES YOUR JOB REQUIRE YOU TO PERFORM THE FOLLOWING ACTIVITIES?
☐ LIFT ☐ SIT ☐ USE A COMPUTER
☐ BEND ☐ STAND ☐ LIFT OR REACH OVER HEAD

DOES YOUR JOB REQUIRE HEAVY LIFTING? ☐ YES ☐ NO
IF YES, WHAT IS THE MAXIMUM WEIGHT? _____LBS. _____/HR., _____/DAY

SIGNATURE OF PATIENT: ____

SIGNATURE OF PERSON FILLING OUT FORM:____
(IF OTHER THAN PATIENT)

Beacon Orthopaedics & Sports Medicine **New Patient Questionnaire**

Patient Name: ____ DATE OF BIRTH:_____________

REVIEW OF SYSTEMS

Check all Positive symptoms

General-
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ General Weakness
- ☐ Trouble sleeping

Skin-
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes

Head-
- ☐ Headache
- ☐ Head injury

Eyes-
- ☐ Vision Loss
- ☐ Blurry or double vision
- ☐ Flashing lights

Ears-
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

Nose-
- ☐ Stuffiness
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Throat-
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

Musculoskeletal-
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints

Neck-
- ☐ Pain
- ☐ Stiffness
- ☐ Lumps
- ☐ Swollen glands

Respiratory-
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular-
- ☐ Chest pain or discomfort
- ☐ Chest Tightness
- ☐ Palpations
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing lying down
- ☐ Leg Swelling
- ☐ Sudden awaking from sleep with shortness of breath

Gastrointestinal-
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

☐ **Negative Response to All Symptoms**

Neurologic-
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness or tingling hands or arms
- ☐ Numbness or tingling feet or legs
- ☐ Tremor

Vascular-
- ☐ Calf pain with walking
- ☐ Leg cramping

Hematologic-
- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine-
- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

Urinary-
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence

Psychiatric-
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss
- ☐ Panic Attacks
- ☐ Insomnia
- ☐ Bipolar

Beacon Orthopaedics & Sports Medicine **New Patient Questionnaire**

Date: ______________________ **Physician Signature:** ______________________________

Patient Name: ____ DATE OF BIRTH:______________

SPINE QUESTIONNAIRE

List ALL symptoms for why you are here (Reason for Visit): ☐ Pain ☐ Numbness/Tingling ☐ Muscle Weakness ☐ OTHER
____

How did the symptoms BEGIN?
- ☐ Spontaneously with no known cause
- ☐ As a result of an AUTOMOBILE accident – Date of Auto Accident: ___/___/___
- ☐ As a result of an injury at WORK – Date of Injury: ___/___/____
- ☐ As a result of an injury outside of work

My pain is located in my:
☐ Neck ☐ Low back ☐ Mid---Back ☐ Other: ______________________________

Rate your pain: Use this PAIN SCALE of *0 to 10* (*0*=NO PAIN AND *10*=WORST POSSIBLE PAIN) for each affected area:

Neck _____/10 Low Back_____/10 Mid---Back_____/10 Other affected areas: ______/10

If you have NECK and/or ARM pain: What percentage of the pain is in your NECK? _______%
What percentage of the pain is in your ARM(s) + _______%
Total Arm/Neck Pain:___100_% (should be 100%)

If you have BACK and/or LEG pain: What percentage of the pain is in your BACK? _______%
What percentage of the pain is in your LEG(s) + _______%
Total Back/Leg Pain: _100__% (should be 100%)

The PAIN is: ☐ Constant ☐ Intermittent

The PAIN is described as: ☐ Sharp/Stabbing ☐ Dull/Aching ☐ Burning ☐ Throbbing

The symptoms *IMPROVE* with: ☐ Standing ☐ Walking ☐ Sitting ☐ Lying Down
The symptoms *GET WORSE* with: ☐ Standing ☐ Walking ☐ Sitting ☐ Lying Down ☐ Bending ☐ Bowel Movements ☐ Sneezing ☐ General Activity

Since your condition started, have you experienced any bladder dysfunction? ☐ Yes ☐ No

How long can you stand with NO or MINIMAL PAIN? _____ Minutes ☐ No problem standing for long periods of time.

What distance can your walk with *NO or MINIMAL PAIN*?
☐ up to 1 block ☐ 2---3 blocks ☐ 6 blocks ☐ No Limit

Do you need SUPPORT to help you walk? ☐ YES ☐ NO
If yes, specify:
☐ Use a WHEELCHAIR ☐ Use a WALKER ☐ Uses a CANE
☐ Must rely on some PERSON or FURNITURE for support to walk

Do you wear a NECK or BACK brace?
If yes, ☐ Neck Brace ☐ Back Brace

How long have you worn the brace?
___Days _____Weeks _____Months _____Years

Please check mark the pictures with all symptoms that apply by using the following letters on the picture:

P = Pain
N = Numbness/Tingling
W = Weakness
R = Radiates *(moves from main are into other areas of the body)*