345 Clyde Morris Blvd Suite 390
Ormond Beach Fl, 32174
386-673-0075

GUPTA SPORTS & SPINE CENTER

NEW PATIENT INFORMATION FORM -*ORTHO*

Please print all information. Thank you for your cooperation.

Patient Name: _____

Date of Birth: _____ Social Security #_____

Address: _____

City: _____

State: _____ Zip Code:_____

Phone (home):_____ Work/Cell: _____

Employer: _____

Marital Status: Single Married Divorced Widowed

Email Address: _____

Is it ok to mail correspondence such as reminders and letters to you? ____Yes ____No

Referring Physician or Referral Source:
_____

Primary Care Physician:
_____

Do you want your medical records sent to this practice? ___Yes ___No

Insurance Plan: _____
Group Number: _____ Policy Number: _____
Issue Date: _____

Secondary Insurance Plan: _____
Group Number: _____ Policy Number: _____
Issue Date: _____

Thank you for taking the time to complete our intake forms. Please sign & date (below)

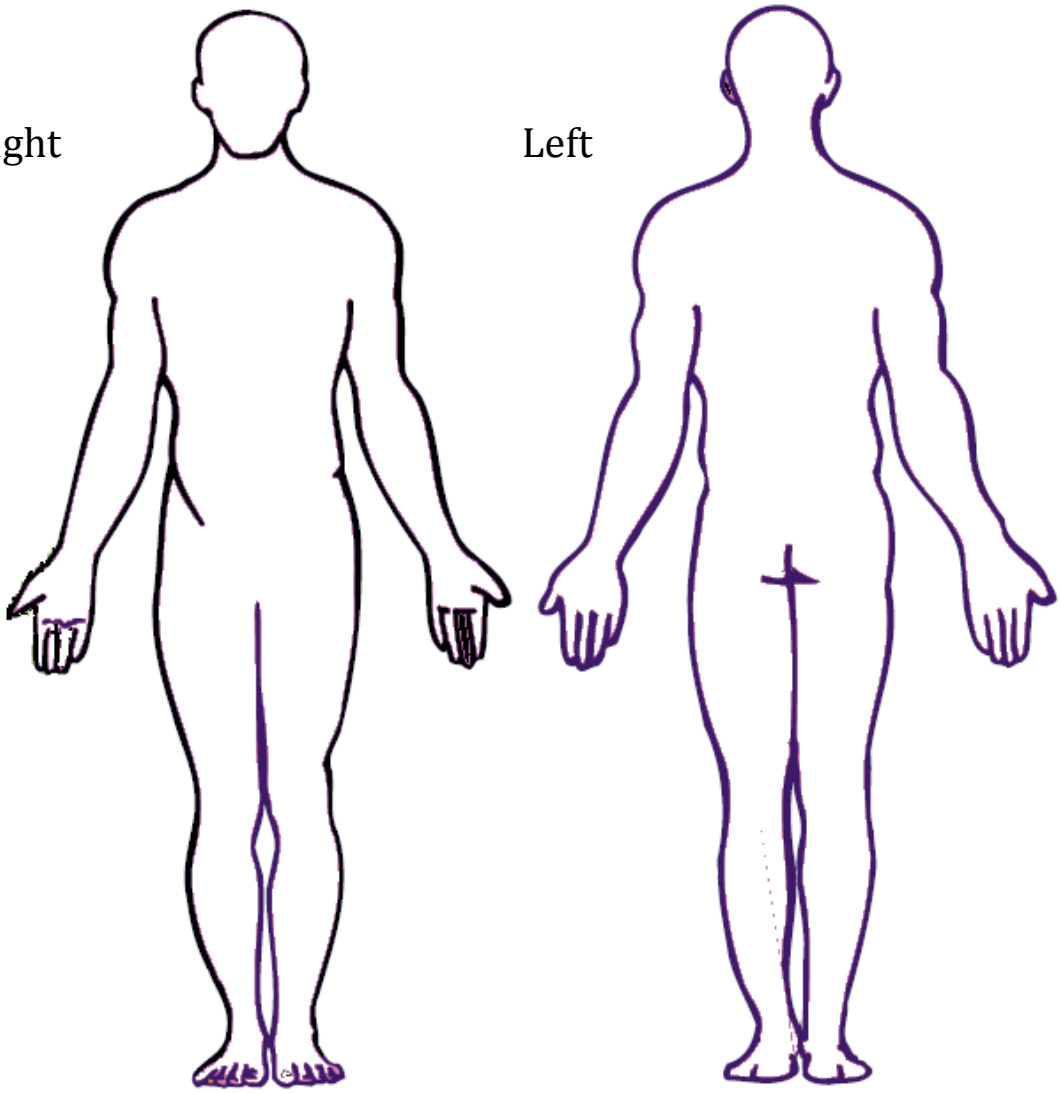
_____ _____
Patient's Signature Today's Date

Pain Drawing

Instructions: Mark these drawings according to where you hurt. Please use the key below to indicate which sensations you are experiencing.

Key: Stabbing //// Pins/Needles 0000 Numbness ==== Burning XXXX Aching ++++

Right Left Right



Circle your current pain level and place a check next to your lowest and highest levels.

0 1 2 3 4 5 6 7 8 9 10

0 No Pain
1 Mild pain; you are aware of it, but it doesn't bother you
2 Moderate pain that you can tolerate without medication.
3 Moderate pain that requires medication to tolerate.
4-5 More severe pain; you begin to feel antisocial.
6 Severe pain.
7-9 Intensely severe pain.
10 Most severe pain

HISTORY OF PRESENT COMPLAINT

1. Age:_____ Male Female Pain is on which side: Right Left
2. Where is your problem located? _____
3. How long have you had this problem? _____Since? _____/_____/_____
4. Briefly, please give the details of how this problem originally started:
   _____
   _____
   _____
5. Please describe your present pain/problem now (*what you feel, where,when, etc.)*
   _____
   _____
   _____
   _____
6. What have you tried to improve your pain? (medications, therapy, other doctors)
   _____
   _____
   _____
   _____
   _____
7. Have you had any imaging (X-Ray, MRI, etc) done for this area? And if so where and when?
   _____
   _____
   _____
   _____

Past Medical History:

No Medical History	COPD	Kidney Disease	Seizures
Please circle all that apply	Emphysema	Stroke/CVA	Osteoarthritis
Hypertension	Obstructive Sleep Apnea	Headaches/Migraines	Rheumatoid Arthritis
Congestive Heart Failure	Hepatitis	Anemia	Gout
Abnormal Heart Rhythm	Diabetes Type 1 2	Lupus	Endometriosis
Heart Disease, CAD	Hypothyroidism	Reflux	Cancer (specify type)
Peripheral Vascular Dz	Hyperthyroidism	Irritable Bowel	
Blood Clots /DVT	Enlarged Prostate/BPH	Anxiety	Other _____
High Cholesterol	Osteoporosis	Depression	

Past Surgical History:

No Surgical History	Tonsil	Eye	Hip Replacement
Please circle all that apply	Thyroid	Ear	Knee Surgery
Heart Bypass	Appendix	Prostate	Neck Surgery- Fusion
Heart Pacemaker	Gallbladder	Kidney	Back Surgery-Fusion
Angioplasty Stent	Gastric Bypass	Bladder	Other _____
Brain	Hysterectomy	Hernia	
Lung	C-Section	Shoulder – Rotator Cuff	

Family History:

Relative	***Age/Living***	***Health Problems***
Father		
Mother		
Brother		
Sister		

Allergies (to medications and food)

_____

Medications:

(please include all herbal supplements and/or vitamins)

SOCIAL HISTORY

1. Current work status_____ Occupation: _____

2. Marital Status: Single Married Divorced Widowed

3. Number of Children: _____

4. I live: Alone With: _____ I live in a: House Apartment Nursing Facility

5. Are you a cigarette smoker? No Yes How old were you when you began smoking? _____
   How much do you smoke daily? _____ When did you quit smoking? _____

6. Do you drink any alcoholic beverages: (check one) No Yes
   1 2 3 4 5 6 drinks daily weekly monthly social use only

7. Have you ever had a problem with drug dependence? Yes No

8. Please write any additional information that you feel is important for us to know.

_____

_____

REVIEW OF SYTEMS

Do you currently have any of the following medical symptoms?

General
- o Unexplained weight loss
- o Appetite change
- o Fevers or chills
- o Night sweats
- o Marked fatigue
- o Difficulty sleeping

Eyes
- o Glasses
- o Change in vision
- o Double vision

Ear, Nose, Throat
- o Difficulty swallowing
- o Hoarseness
- o Loss of hearing
- o Ear pain
- o Nosebleeds

Cardiovascular
- o Heart or chest pain
- o Abnormal heartbeat
- o Leg swelling

Respiratory
- o Morning cough
- o Shortness of breath
- o Productive cough or sputum

Digestive
- o Nausea or vomiting
- o Stomach pain or ulcers
- o Heart burn
- o Diarrhea
- o Constipation
- o Uncontrolled loss of stool
- o Blood in stools

Skin
- o Rashes
- o Itchiness
- o Easy bruising

Neurological
- o Seizures
- o Blackouts/fainting
- o Headaches/migraines

Musculoskeletal
- o Joint pains
- o Joint swelling
- o Numbness in feet/hands
- o Muscle weakness

Genitourinary
- o Burning on urination
- o Incontinence
- o Pelvic pain
- o Impotence
- o Abnormal Bleeding

Psychiatric
- o Depression
- o Anxiety
- o Paranoia

Other

_____

_____

_____

_____

_____