Date:_____

PATIENTS NAME:_____ AGE:_____ SEX:_____

D.O.B.:_____

D.O.I.:_____

BODY PART INJURED:_____

PRESENT COMPLAINT:_____

HOW WERE YOU INJURED:_____

IS THIS INJURY WORK OR AUTO RELATED?_____

Height:_____

WEIGHT:_____

REFERRING PHYSICIAN:_____

RT. OR LT. HANDED:_____

PREVIOUS X-RAYS: _____YES _____NO

ALLERGIES TO MEDICATIONS:_____

MEDICATIONS:_____

WORK STATUS:_____

Permanent and Stationary (P&S)? Yes _____ No _____

When? _____ Work Status: _____

WORKERS' COMPENSATION MEDICAL HISTORY QUESTIONNAIRE

Name: _____, _____ Date: _____
Last First

Age:_____ Date of Birth:_____ Height: _____ Weight:_____ Hand Dominance: Right ☐ Left ☐

Primary Care Physician: _____ Referring Physician: _____

HISTORY OF PRESENT WORK-RELATED INJURY OR ILLNESS

On what date did the injury occur or symptoms begin? _____

Who was your employer at the time of injury? _____

What was your job title?_____

What were your basic job duties? _____

What were the physical demands of your job? Examples: Bending, stooping, lifting (in pounds), walking, climbing, driving, typing, etc. _____

_____

How did the injury occur? Please be specific. _____

_____

_____

What body parts were injured? _____

Did you report the injury to your employer? Yes ☐ No ☐ To Whom? _____ When? _____

What action did your employer take? _____

COURSE OF TREATMENT

Have you ever seen another physician/healthcare provider in relation to this work-related injury? Yes ☐ No ☐

If yes, please provide physician's/provider's name:_____

Are you currently being treated for this work-related injury? Yes ☐ No ☐

If yes, please provide physician's/provider's name:_____

What treatments, if any, have you received for this work-related injury?

Medication ☐ Physical Therapy ☐ Pain Management ☐ Cortisone Shots ☐ Casting ☐ Bracing ☐

Have you ever had surgery for this work-related injury? Yes ☐ No ☐ If yes, please indicate:

Date/Year	Procedure	Date/Year	Procedure
_____	_____	_____	_____
_____	_____	_____	_____

What diagnostic studies, if any, have you had for this work-related injury?

X-rays ☐ MRI ☐ CT scan ☐ EMG/NCV ☐ Bone scan ☐ Discogram ☐

WORK HISTORY

Are you currently employed? Yes ☐ No ☐ Current employer: _____

Current work status: Full duty ☐ Light duty ☐ Off work ☐ Last day worked: _____

At the time of this injury, were you working full-time ☐ or part-time ☐? Did you work overtime? Yes ☐ No ☐

Did you have more than one job at the time of this work-related injury? Yes ☐ No ☐

List all employers for the last 10 years, starting with the most recent:

Employer	Job Title/Job Duties	How Long?
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT COMPLAINTS

Body part(s) injured:	What symptoms are you having in the injured body part(s)?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prior to the current injury, did you have impairment or disability in these body parts from injury? Yes ☐ No ☐

If yes, please provide details: _____

Has this injury affected your activities at work? Yes ☐ No ☐

If yes, please explain: _____

Has this injury affected your activities of daily living (self-care tasks, such as personal hygiene and grooming, dressing and undressing, self-feeding, getting into and out of bed, getting onto and off toilet, walking/ambulation, bowel/bladder management, housework, shopping, cooking, driving, etc.)? Yes ☐ No ☐

If yes, please explain: _____

_____

Has this injury affected any hobbies, sporting, volunteer, or recreational activities that you perform on a regular basis? Yes ☐ No ☐

If yes, please explain: _____

_____

PAST MEDICAL HISTORY

ACCIDENTS/INJURIES

Prior to the current injury, did you ever have any other injuries? Yes ☐ No ☐

Prior injuries, work-related or not:

Body part(s) injured (be specific, e.g., neck, upper Back, lower back, specific part of extremity)	Date	Employer

Prior to the current injury, did you ever have injury to these body parts that was not work-related? Yes ☐ No ☐

Prior injuries, not work-related:

Body part(s) injured (be specific, e.g., neck, upper Back, lower back, specific part of extremity)	Date

Prior to the current injury, did you ever receive a Workers' Compensation settlement for these injured body parts or other body parts?

Yes ☐ No ☐ If yes, please provide details: _____

MEDICAL ILLNESSES

Do you have any of the following conditions?

High Blood Pressure	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐	Cancer	Yes ☐ No ☐
Thyroid Disease	Yes ☐ No ☐	Stroke	Yes ☐ No ☐	What Type?	_____
Diabetes Mellitus	Yes ☐ No ☐	Ulcer	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐	Lupus	Yes ☐ No ☐	What Type?	_____
Seizure Disorder	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	Asthma	Yes ☐ No ☐

Have you ever been diagnosed with HIV/AIDS? Yes ☐ No ☐

Have you ever been diagnosed with chronic hepatitis? Yes ☐ No ☐ Which hepatitis, A, B, or C? _____

PREVIOUS SURGERIES/HOSPITALIZATIONS

What surgeries (other than those previously listed) have you had in the past? _____

_____

What hospitalizations have you had in the past? _____

_____

CURRENT MEDICATIONS

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Do you have any allergies to medication or other substances? Yes ☐ No ☐

If yes, please list and describe reaction: _____

FAMILY HISTORY

Which medical illnesses does your mother have? (please check which apply)

High Blood Pressure	_____	Heart Disease	_____	Cancer	_____
Thyroid Disease	_____	Stroke	_____	What Type?	_____
Diabetes Mellitus	_____	Ulcer	_____	Arthritis	_____
Kidney Disease	_____	Lupus	_____	What Type?	_____
Seizure Disorder	_____	Emphysema	_____	Asthma	_____

Which medical illnesses does your father have? (please check which apply)

High Blood Pressure	_____	Heart Disease	_____	Cancer	_____
Thyroid Disease	_____	Stroke	_____	What Type?	_____
Diabetes Mellitus	_____	Ulcer	_____	Arthritis	_____
Kidney Disease	_____	Lupus	_____	What Type?	_____
Seizure Disorder	_____	Emphysema	_____	Asthma	_____

SOCIAL HISTORY

Do you use the following?

Alcohol Yes ☐ No ☐ How often? _____ drinks per (day/week/month). How many years? _____
(please circle)

Cigarettes Yes ☐ No ☐ How many packs per day? _____ How many years? _____

Recreational Drugs Yes ☐ No ☐ How often? _____ How many years? _____

Please list which recreational drug(s): _____

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

Do you have children? Yes ☐ No ☐ How many? _____

REVIEW OF SYSTEMS

Do you CURRENTLY have? (if yes, please check appropriate boxes)

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Fatigue

SKIN
- ☐ Nail changes
- ☐ New lesions
- ☐ Rash
- ☐ Skin color changes

HEENT
- ☐ Double vision
- ☐ Eye pain
- ☐ Eye redness
- ☐ Decreased hearing
- ☐ Earache
- ☐ Ear ringing
- ☐ Nosebleeds
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Oral ulcers
- ☐ Sore throat

RESPIRATORY
- ☐ Chronic cough
- ☐ Decreased exercise tolerance
- ☐ Difficulty breathing
- ☐ Coughing up blood
- ☐ Sputum production
- ☐ Wheezing

BREAST
- ☐ Breast mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Skin changes

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Leg pains with walking
- ☐ Leg swelling
- ☐ Night awakening due to trouble breathing
- ☐ Palpitations
- ☐ Shortness of breath

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Trouble swallowing
- ☐ Reflux

GENITOURINARY
- ☐ Vaginal discharge
- ☐ Menstrual irregularities
- ☐ Difficulty starting/stopping urinary stream
- ☐ Painful urination
- ☐ Change in urinary stream
- ☐ Increased frequency
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Nighttime urination
- ☐ Urinary retention
- ☐ Urethral discharge
- ☐ Impotence
- ☐ Penile lesions
- ☐ Testicular mass
- ☐ Testicular pain

MUSCULOSKELETAL
- ☐ Neck pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling

NEUROLOGICAL
- ☐ Loss of bowel control
- ☐ Dizziness/vertigo
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in sleep pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal thoughts

ENDOCRINE
- ☐ Appetite changes
- ☐ Cold intolerance
- ☐ Increased thirst
- ☐ Increased urination
- ☐ Hair changes
- ☐ Sexual dysfunction

HEMATOLOGY
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Prolonged bleeding

If you have completed all sections in the above form and all responses are true to the best of your knowledge, please sign and date below.

Signature: _____ **Date:** _____

Scott Goldman, M.D.
Orthopedic Surgery • Sports Medicine

PAIN MANAGEMENT AGREEMENT/INFORMED CONSENT

Please initial each statement that you have read and agree with:

_____ The purpose of this Agreement is to prevent misunderstanding about certain medications you will be taking for pain management. This is to help you and your physician to comply with the laws regarding controlled pharmaceuticals.

_____ I will tell my physician about any and all medications and treatments that I am receiving.

_____ I will make my physician aware of any other pain medications prescribed by other physicians.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

_____ I understand that if I break this Agreement, my doctor may stop prescribing these pain control medications.

_____ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how the medications are helping to relieve the pain and increase my functioning, as well as any side effects.

_____ I will take my medications only as prescribed; if my pain is not being controlled, I will contact my physician for instructions.

_____ I will not take it upon myself to change any dosage directions for my prescribed medications without prior approval from my physician.

_____ I will not change, alter or forge any medications on my prescription, and I am aware that this will cause me to be discharged immediately from the practice.

_____ I will not use any illegally controlled substances, including marijuana, heroin, cocaine, etc.

_____ I am aware not to drink alcohol while taking pain medications.

_____ I am aware that the use of long term pain medication may result in certain side effects such as: Sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of reflexes or reaction time, physical dependence, tolerance to opioids, addiction and the likelihood that the medication may not provide complete pain relief.

_____ I understand that physical dependency is not the same as addiction. I am aware that physical dependence means that if my pain medication use is significantly decreased or stopped, I may experience withdrawal symptoms and have signs and symptoms such as runny nose, yawning, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches through the body or flu-like feeling.

_____ I will not share, sell or trade my medications with anyone.

_____ I will not attempt to obtain any controlled medication, including opioid pain medications, controlled stimulants, or anti-anxiety medications, from any other doctor, unless agreed upon with both physicians.

_____ (Females Only) If there is a possibility that I may become pregnant or plan to get pregnant, it is my responsibility to notify this office immediately.

_____ I am aware of the options and possible risks and benefits of other types of treatment that do not involve the use of opioids.

_____ I will safeguard my pain medications from loss or theft. Lost or stolen medications will not be replaced. If in any case my prescription is stolen I must obtain a police report before a new prescription Is given.

_____ I agree that refills on my prescriptions for pain medications will be made only at the time of an office visit or during regular business hours. No refills will be available during evenings, weekends, holidays, or Friday afternoons.

_____ I agree to have my spouse/family member present at my office visit if requested by my physician to discuss my treatment plan and/or recommendations for future medical care, especially in terms of medication treatments.

_____ I understand that any abusive behavior or profanity will not be tolerated by the staff or physician under any circumstances, and this may result in discharge.

_____ I understand that I may be subject to random drug testing at any time if requested by my physician and I may not refuse.

_____ I agree to use _____ pharmacy, located at _____, telephone number _____ for filling prescriptions for my pain medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the States Board of Pharmacy and the Drug Enforcement Agency, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this.

Authorizations.

Signature: _____ Date: _____

Medical Center for Bone & Joint Disorders, Inc.
A California professional medical corporation
400 N. Mountain Avenue, Suite 310
Upland, California 91786

Privacy Officer: Kristen Smedley

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices, that I have been advised that a copy of the current Notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Medical Center for Bone & Joint Disorders, Inc.
HIPAA Notice of Privacy Practices
Acknowledgment and Tracking Information

Name of Patient: _____

I authorize Scott Goldman M.D. and staff to provide and/or discuss my care and medical needs with the following individuals.

	Name	Relation	Phone
1.			
2.			

I grant permission for Scott Goldman M.D. and staff to leave detailed messages at the following phone number.

_____ - _____ - _____

Type:

__Home
__Work
__Cell

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: ☐☐Yes ☐☐ No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

Patient Disclosure Statement

I, _____ understand that my physician has the ability to provide me with medications that I may need for my treatment. However, I understand that I will always be given the option to receive a written prescription that I may have filled at a pharmacy of my choice.

Signature: _____ Date: _____

Yo,_____ entiendo que mi medico tiene la habilidad de proveerme con alguna de la medicina necesaria para mi tratamiento. Sin embargo, entiendo que siempre tendre la opcion de recibir una receta escrita y adquirirla en la farmacia de mi preferencia.

Firma:_____ Fecha:_____

(TO BE PLACED IN PATIENT FILE)

Pharmacy Laws California Edition/Business and Professions Health and Safety Civil Article 12 Prescirber Dispensing Part 4170 (6)

website: www.mcboneandjoint.com

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