Drew A. Stein, MD

PATIENT INFORMATION SHEET

Name: _____ Age: _____ Birth Date: _ _ / _ _ / _ _ SS#: _____

ADDRESSES

Home Address: _____
Apt #: _____
City/State/Zip: _____
Employer: _____

_____
Work Address: _____
Occupation: _____

CONTACT NUMBERS

Home Phone: (_ _ _) _ _ _-_ _ _ _
Work Phone: (_ _ _) _ _ _-_ _ _ _
Cell Phone: (_ _ _) _ _ _-_ _ _ _
Fax: (_ _ _) _ _ _-_ _ _ _
Email:

Marital Status: _____

REFERRAL INFORMATION

Referral Source:_____

Primary MD: _____
Address: _____
Phone: _____

INSURANCE INFORMATION

Insurance Company: _____

Policy #: _____

PHARMACY INFORMATION

Pharmacy Name: _____
Pharmacy Phone #: _____

INJURY INFORMATION

Date of Injury: _ _ / _ _ / _ _

Height _____ Weight _____

Body Part Injured: _____

Hand Dominance: Right Left Both

Type of Pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Constant ☐ Radiating

Intensity of Pain: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Low Pain *Moderate Pain* *Intense Pain*

Pain at night? ☐ Yes No ☐ *scribe the pain* _____

What makes it worse? _____

What makes it better? _____

Previous treatment for this problem? _____

Past Medical History: (please circle all that apply)

Anxiety	Colon Cancer	Diabetes	Hypertension	Prostate Cancer
Arthritis	COPD	End Stage Renal	HIV/AIDS	Radiation Treatment
Artificial joints	Coronary Artery	GERD	High Cholesterol	Seizures
Asthma	Disease	Hearing Loss	Hyperthyroidism	Stroke
Atrial fibrillation	Colon Cancer	Hepatitis	Hypothyroidism	Valve Replacement
BPH	COPD	Hypertension	Leukemia	
Bone Marrow	Coronary Artery	HIV/AIDS	Lung Cancer	**NONE (Please**

Transplantation Breast Cancer	Disease Depression	Hypercholesterolemia Hepatitis	Lymphoma Pacemaker	**Circle)** **Other**_____ _____

Past Surgical History: (please circle all that apply)

Appendix Removed Bladder Removed Mastectomy: *(Right, Left, Both)* Lumpectomy: *(Right, Left, Both)* Breast Biopsy: *(Right, Left, Both)* Breast Reduction Breast Implants Colectomy: Colon Cancer Resection Colectomy: Diverticulitis Colectomy: IBD Gallbladder Removed	Coronary Artery Bypass PTCA Mechanical Valve Replacement Biological Valve Replacement Heart Transplant Joint Replacement within last 2 years Kidney Biopsy Kidney Removed: *(Right, Left)* Kidney Stone Removal	Kidney Transplant Ovaries Removed: Endometriosis Ovaries Removed: Cyst Ovaries Removed: Ovarian Cancer Prostate Removed: Prostate Cancer Prostate Biopsy TURP Skin Biopsy Basal Cell Cancer Surgery Squamous Cell Carcinoma Surgery Melanoma Surgery	Spleen Removed Testicles Removed *(Right, Left, Both)* Hysterectomy: Fibroids Hysterectomy: Uterine Cancer **None (Please Circle)** **Other** _____ _____

Orthopedic History: (please circle all that apply)

Ankylosing Spondylitis Bursitis DISH Distal Radius Fracture Epidural Injections Gout Hip Fracture HNP, Cervical HNP, Lumbar	Metastatic Bone Disease Osteoarthritis Osteopenia Osteoporosis Primary Bone Sarcoma Psoriatic Arthritis Ricketts	RSD Sciatic Scolisis Soft Tissue Sarcoma Spinal Stenosis, Cervical Spinal Stenosis, Lumbar	Vertebral Body Compression Fracture Vitamin D Deficiency **None** **(Please Circle)** **Other** _____

Orthopedic Surgery: (please circle all that apply)

Ankle Fracture: *(Right, Left, Both)* Carpal Tunnel Decompression: *(Right, Left, Both)* Cervical Spine Surgery: ACDF Cervical Spine Surgery: Disc Replacement Distal Radius ORIF: *(Right, Left, Both)*	Intermedullary Nailing Femur *(Right, Left, Both)* *)* Intermedullary Nailing Tibia: *(Right, Left, Both)* Joint Replacement: Hip *(Right, Left, Both* Joint Replacement: Knee *(Right, Left, Both)* Joint Replacement: Shoulder *(Right, Left, Both)*	Knee Arthroscopy: *(Right, Left, Both)* Kyphoplasty/Vertebroplasty Lumbar Spine Surgery: Decompression Lumbar Spine Surgery: Decompression and Fusion Lumbar Spine Surgery: Disc Replacement Rotator Cuff Repair: *(Right, Left, Both)* None (Please circle) Other _____

Family History: (please circle all that apply)

Charcot Marie Tooth Disease
Diabetes
Hypertension
Multiple Hereditary Exostosis
Osteoarthritis
Osteoporosis
Scoliosis
None
Other _____

Medications: (Please list all current medications)

_____
_____
_____

None (Please Circle)

Allergies: (Please enter all allergies)

_____
_____

None (Please circle

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol (please circle)	How often do you exercise?
Never smoked Quit: former smoker Smokes less than daily Smokes daily	Yes No	Several times a day Once a day A few times a week A few times a month Never Other