

OSI HAND SURGERY™

KATE KUHLMAN-WOOD, MD

BOARD-CERTIFIED PLASTIC & RECONSTRUCTIVE SURGEON

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HAND & WRIST INTAKE FORM | PERSONAL DEMOGRAPHIC INFORMATION

NAME: _____ DATE: _____
LAST FIRST MIDDLE

S.S.N. [] [] [] [] [] [] [] [] [] [] BIRTH DATE: / / AGE: GENDER: M / F

MAILING ADDRESS: _____
STREET CITY STATE ZIP CODE

PHONE: _____ EMAIL ADDRESS: _____
HOME CELL

MARITAL STATUS: SINGLE MARRIED DIVORCED/SEPARATED WIDOWED

SPOUSE (IF APPLICABLE): _____
NAME BIRTH DATE

PREFERRED LANGUAGE: ENGLISH OTHER _____

RACE: AMERICAN-INDIAN BLACK/AFRICAN-AMERICAN WHITE OTHER _____ DECLINED

ETHNICITY: CENTRAL-AMERICAN HISPANIC / LATINO / SPANISH OTHER _____ DECLINED

INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE:

NAME OF CARRIER	POLICY NUMBER	GROUP NUMBER
SUBSCRIBERS NAME & PATIENT RELATIONSHIP	SUBSCRIBER D.O.B.	INSURANCE PHONE NUMBER

SECONDARY INSURANCE COVERAGE:

NAME OF CARRIER	POLICY NUMBER	GROUP NUMBER
SUBSCRIBERS NAME & PATIENT RELATIONSHIP	SUBSCRIBER D.O.B.	INSURANCE PHONE NUMBER

GUARANTOR INFORMATION (IF UNDER 18) :

NAME PHONE

EMPLOYMENT INFORMATION:

EMPLOYER'S NAME ADDRESS

PATIENT NAME

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PATIENT INFORMATION, CONTINUED

1. HOW DID YOU LEARN ABOUT US, OR WHO REFERRED YOU TO THE ORTHOPEDIC SPECIALTY INSTITUTE™

INFORMATION SOURCE OR NAME OF REFERRER

PHONE

2. WHO IS YOUR PRIMARY CARE PHYSICIAN?

NAME OF PHYSICIAN

PHONE

STREET

CITY

STATE

ZIP

3. WHAT PHARMACY DO YOU USE?

NAME OF PHARMACY

PHONE

STREET

CITY

STATE

ZIP

ARE YOU CURRENTLY TAKING ANY NARCOTICS?

YES

NO

IF YES, NAME? _____

HOW LONG? _____

I agree the **Orthopedic Specialty Institute™** may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE: _____

6. PLEASE LIST ALL MEDICATIONS / HERBS / TEAS YOU CURRENTLY USE:

TYPE / NAME

FREQUENCY

DOSAGE

TYPE / NAME

FREQUENCY

DOSAGE

TYPE / NAME

FREQUENCY

DOSAGE

7. DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? YES NO

IF YES, PLEASE LIST AND DESCRIBE YOUR REACTION TO THE MEDICATION:

MEDICINE ALLERGY

REACTION

PATIENT NAME

CONTINUED ON NEXT PAGE →

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PATIENT INFORMATION, CONTINUED

8. ARE YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH THE FOLLOWING?

	YES	NO		YES	NO
No Past Medical problems reported			Liver Disease		
Anxiety Disorder			Low Back Pain		
Arthritis: Type?			Neck Pain		
Asthma			Mid Back Pain		
Bleeding Disorder			Radiculopathy – Upper		
Blood Clots (Deep Vain Thrombosis)			Radiculopathy – Lower		
Cancer: Type?			Organ Transplant		
CHF			Osteopenia		
Claustrophobic			Osteoporosis		
Coronary Artery Disease			Other Lung Disease		
COPD			Poliomyelitis		
Diabetes Type I			Peripheral Vascular Problem		
Diabetes Type II			Pulmonary Embolism		
Dialysis			Reflux Disease		
Diverticulitis			Rheumatoid Arthritis		
Fibromyalgia			Sciatica		
Gout			Stroke		
Pacemaker			Tuberculosis (TB)		
Heart Arrhythmia			Ulcers		
Heart Attach (MI)			Urinary Tract Infection		
Heart Murmur			Other:		
Hiatal Hernia			Problems with Anesthesia		
HIV or AIDS			Hepatitis		
Hypertension			Hypercholesterolemia		
Hyperthyroidism			Leg / Foot Ulcers		
IBS (Irritable Bowel Syndrome)			Kidney Disease		
Kidney Stones					

9. ARE YOU ALLERGIC TO LATEX OR TAPE? YES NO

10. HAVE YOU EVER HAD MRSA? YES NO

11. HAVE YOU EVER HAD HEPATITIS C or B? YES NO

12. DO YOU DRINK ALCOHOL? YES NO IF YES, HOW MANY DRINKS/WEEK? _____

13. DO YOU SMOKE? YES NO IF YES, PACKS/DAY? _____ HOW LONG? _____

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PATIENT INFORMATION, CONTINUED

14. PLEASE ANSWER THE FOLLOWING QUESTIONS: DO YOU . . .

- HAVE CHILDREN? YES NO IF YES, HOW MANY? _____ TYPE OF DELIVERY? _____
- LIVE ALONE? YES NO IF NO, WITH WHOM? _____
- USE A SPECIAL DIET? YES NO DESCRIBE _____
- USE RECREATIONAL DRUGS? YES NO DESCRIBE _____
- EXERCISE REGULARLY? YES NO HOW OFTEN? _____
- SPORTS OR HOBBIES? YES NO DESCRIBE? _____

15. PLEASE LIST ALL PAST SURGERIES AND HOSPITALIZATIONS:

_____	_____	_____
SURGERY / HOSPITALIZATION	DATE	PHYSICIAN / SURGEON
_____	_____	_____
SURGERY / HOSPITALIZATION	DATE	PHYSICIAN / SURGEON
_____	_____	_____
SURGERY / HOSPITALIZATION	DATE	PHYSICIAN / SURGEON

16. HAVE YOU EVER HAD PROBLEMS WITH GENERAL ANESTHESIA? YES NO

17. FAMILY HISTORY

FAMILY MEMBER	IF ALIVE, AGE & HEALTH STATUS	IF DECEASED, AGE AT TIME OF DEATH & CAUSE
FATHER		
MOTHER		
SIBLING		
SIBLING		
AUNTS		
UNCLES		

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PATIENT INFORMATION, CONTINUED

18. CURRENT VITALS:

HEIGHT	WEIGHT	BRA SIZE
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19. CHIEF COMPLAINT / CURRENT CONCERN:

Which side is your chief complaint or concern? LEFT RIGHT

Describe your chief complaint or concern: _____

How long have you had this problem? _____

Is your problem getting: WORSE BETTER STAYING THE SAME

Was this a result of an injury? YES NO IF YES, WHAT WAS THE DATE OF THE INJURY? _____

If yes, please describe how it happened? _____

19. WORK-RELATED INJURY:

Job Title: _____

How long have you worked for this employer?

Date of Injury: ____ / ____ / ____

Are you: OFF WORK MODIFIED DUTY FULL DUTY

If you are not working full duty, what date did you last do so? ____ / ____ / ____

20. IF PAIN IS ONE OF YOUR COMPLAINTS, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Rate the average intensity of your pain / discomfort. (0=No Pain ; 10=Severe Pain)

	1	2	3	4	5	6	7	8	9	10
Describe your pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	INTERMITTENT	CONSTANT	DULL	SHARP	TIGHT	BURNING	THROBBING	TINGLING		

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PATIENT INFORMATION, CONTINUED

21. TIMING

Is your pain worse at any particular time of the day? MORNING EVENING NIGHT

Does your hand/wrist allow you to sleep comfortably? YES NO

22. ACTIVITY-RELATED SYMPTOMS:

	YES	NO	If YES, please describe
Stiffness			
Numbness			
Tingling			
Swelling			
Weakness			
Pain			
Other			

22. HAVE YOU TRIED ANY OF THE BELOW? RELIEF OF SYMPTOMS?

Medication YES NO Type? _____

Therapy? YES NO If yes, how long did you attend? _____

When was your last session? ____ / ____ / ____

Injections? YES NO If yes, location and medicine? _____

Other YES NO Describe: _____

_____ I acknowledge that I have received the **Notice of Privacy Practices** of the Orthopedic Specialty Institute,™ which explains its legal duties and privacy practices with respect to my protected health information.

By signing below, I agree that all the information provided is true to the best of my knowledge. I also hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for the non-covered services. I also authorize the physician to release any information required to process this claim.

PATIENT SIGNATURE

DATE

I have reviewed the above information in detail with the patient.

KATE KUHLMAN-WOOD, MD

DATE