CHATHAM ORTHOPAEDIC ASSOCIATES, P.A.

RONALD H. LEVIT, MD

Debbie D.
Clinical Assistant

Sheila F.
Board Certified
Nurse Practitioner

** PLEASE FILL OUT COMPLETELY **

WE APPRECIATE YOUR TIME AND EFFORT SPENT COMPLETING THIS FORM

Patient Information

NAME	DATE OF BIRTH	SOCIAL SECURTIY #

PRIMARY CARE PHYSICIAN — OFFICE LOCATION

REFERRED BY — OFFICE LOCATION

AFFILIATION: ☐ MEMORIAL ☐ ST.JOE / CANDLER ☐ SOUTHCOAST ☐ OTHER:

HAVE YOU SEEN DR. LEVIT BEFORE? ☐ NO ☐ YES; IF SO ☐ NEW PROBLEM ☐ SAME PROBLEM

IS THIS PROBLEM: ☐ WORK RELATED ☐ AUTOMOBILE ACCIDENT ☐ PERSONAL INJURY ☐ HAVE YOU FILED A CLAIM ☐ CONSIDERING FILING A CLAIM

Medical History

** PLEASE MARK ALL CURRENT AS WELL AS PREVIOUS ILLNESSES **

☐ HYPERLIPIDEMIA	☐ DIABETES, TYPE I	☐ SLEEP APNEA	☐ THYROID DISORDER	☐ HIV OR AIDS
☐ LUPUS	☐ DIABETES, TYPE II	☐ HEART ATTACKS	☐ SEIZURES	☐ HEPATITIS
☐ SCLERODERMA	☐ PSORIASIS	☐ BLEEDING DISORDERS	☐ MENTAL ILLNESS	☐ CANCER, TYPE:
☐ GOUT	☐ HIGH BLODD PRESSURE	☐ STROKES	☐ STOMACH ULCERS	☐ RHEUMATOID ARTHRITIS
☐ FIBROMYALGIA	☐ CARDIAC ARRYTHMIAS	☐ ASTHMA	☐ BLOOD CLOTS	☐ GERD

☐ OTHER MEDICAL CONDITIONS THAT AFFECT YOUR BONES OR JOINTS:

☐ NONE

PLEASE LIST ALL CURRENT MEDICATIONS, SUPPLEMENTS & HERBAL REMEDIES:

☐ NONE

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ NO ☐ YES; PLEASE LIST:

ARE YOU ALLERGIC TO LATEX? ☐ NO ☐ YES

PLEASE LIST ALL PREVIOUS SURGERIES:

☐ NONE

ARE THERE ANY ILLNESSES THAT RUN IN YOUR FAMILY? ☐ RHEUMATOLOGIC DISORDERS ☐ CANCER ☐ BLEEDING DISORDERS
☐ HEART PROBLEMS ☐ DIABETES ☐ OTHER:

DO YOU USE TOBACCO PRODUCTS? ☐ NEVER ☐ OCCASIONALLY ☐ DAILY ☐ QUIT; HOW LONG AGO:

DO YOU DRINK ALCOHOLIC BEVERAGES? ☐ NEVER ☐ MODERATE ☐ DAILY

HISTORY OF SUBSTANCE ABUSE? ☐ NO ☐ YES; PLEASE EXPLAIN:

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

FALLS IN THE LAST YEAR: ☐ YES ☐ NO EXPLAIN: _____

_____

_____

** PLEASE MARK ALL CURRENT OR PREVIOUS SYMPTOMS **

☐ SIGNIFICANT WEIGHT LOSS	☐ SHORTNESS OF BREATH	☐ SEASONAL ALLERGIES	☐ ANEMIA
☐ FEVERS OR CHILLS	☐ CHRONIC COUGH	☐ HEART BURN	☐ PAST BLOOD TRANSFUSIONS
☐ BLURRED OR DOUBLE VISION	☐ HOT OR COLD INTOLERANCE	☐ LIGHTHEADED OR DIZZY	☐ EXPOSURE TO HIV
☐ HEARING LOSS OR RINGING	☐ SKIN RASHES OR ITCHING	☐ TREMORS	☐ EXPOSURE TO HEPATITIS
☐ CHRONIC SINUS PROBLEMS	☐ FREQUENT OR PAINFUL URINATION	☐ PARALYSIS	☐ OSTEOPOROSIS
☐ BLEEDING PROBLEMS	☐ LOSS OF APPETITE	☐ DEPRESSION OR MANIA	☐ MULTIPLE FRACTURES
☐ CHEST PAIN OR PALPITATIONS	☐ CHRONIC VOMITING	☐ MEMORY LOSS	
☐ FOOT & LEG SWELLING	☐ CHRONIC DIARRHEA	☐ INSOMNIA	

☐ NONE

AGE	ARE YOU: ☐ RIGHT HANDED ☐ LEFT HANDED	SEX: ☐ MALE ☐ FEMALE

REASON FOR VISIT	☐ RIGHT ☐ LEFT ☐ BOTH	DATE OF ONSET / ACCIDENT

HOW DID THE PROBLEM START OR INJURY OCCUR

MY PROBLEM IS: ☐ SHARP PAIN ☐ NUMBNESS ☐ BURNING ☐ WEAKNESS ☐ STIFFNESS ☐ LOCKING / POPPING ☐ THROBBING ☐ OTHER:

MY PROBLEM BOTHERS ME: ☐ AT REST ☐ WITH ACTIVITY ☐ IN THE MORNING ☐ AFTERNOON ☐ EVENING ☐ ALL DAY ☐ AT WORK
☐ WAKES ME UP FROM SLEEP ☐ OTHER:

MY SYMPTOMS IMPROVE WITH:

MY SYMPTOMS WORSEN WITH:

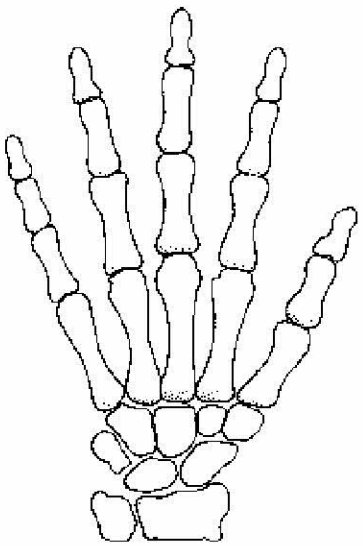
HAVE YOU BEEN TREATED ELSEWHERE? ☐ NO ☐ YES	WHERE:	BY WHOM:
X-RAYS TAKEN: ☐ NO ☐ YES; WHEN: WHERE: DID YOU BRING TO VISIT? ☐ NO ☐ YES	MRI OR CT SCAN: ☐ NO ☐ YES; WHEN: WHERE: DID YOU BRING TO VISIT? ☐ NO ☐ YES	NERVE STUDIES: ☐ NO ☐ YES; WHEN: WHERE: DID YOU BRING TO VISIT? ☐ NO ☐ YES

PREVIOUS TREATMENTS: ☐ PHYSICAL THERAPY ☐ INJECTIONS, HOW MANY: ___ ☐ SURGERY, BY WHOM: _____ ☐ SPLINTS / BRACES
☐ CHIROPRACTOR ☐ ACUPUNCTURE ☐ STEROIDS / CORTISONE BY MOUTH ☐ MASSAGE
☐ ANTI-INFLAMMATORY MEDICATIONS: IBUPROFEN/MOTRIN, NAPROXEN/ALEVE, CELEBREX, MOBIC, ETC.
☐ OTHER:
☐ **NONE**

ARE YOU CURRENTLY WORKING? ☐ YES, FULL DUTY ☐ YES, LIGHT DUTY
☐ NO; IF NOT WHY? ☐ RETIRED ☐ DISABLED ☐ OTHER:

HEIGHT	WEIGHT

OFFICE USE ONLY



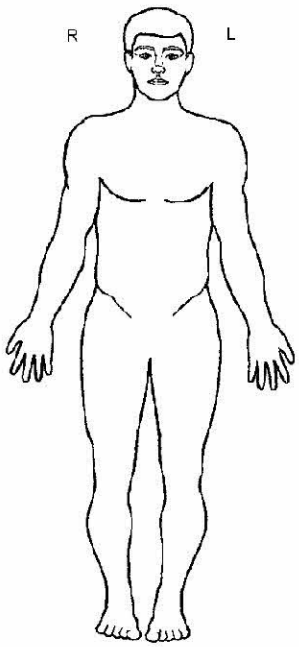
ON THE DRAWINGS BELOW, PLEASE SHADE IN THE LOCATION OF YOUR SYMPTOMS

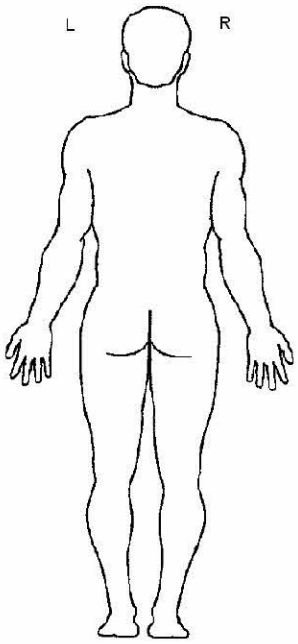
PAIN
XXXXX

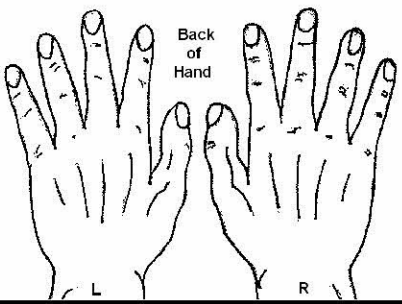
NUMBNESS
//////

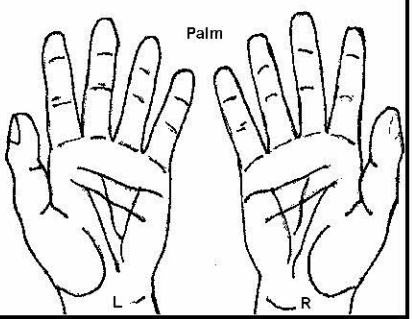
BURNING
oooo

ACHE
_____









PATIENT SIGNATURE	DATE	PHYSICIAN SIGNATURE	DATE