Chatham Orthopaedic Associates, P.A.

Gerald Chai, DO
Raphael Roybal, MD
Dmitri Sofianos, MD

Susan Daughery, NP
Malissa Nix, PA
Jody Stanton, PA

** 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 Drs. Chai, Roybal, Sofianos or Jody, PA before? ☐ No ☐ Yes; list provider: ______________________________
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 **

☐ Rheumatoid arthritis	☐ 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	☐ Kidney disorders
☐ Fibromyalgia	☐ Cardiac arrythmias	☐ Asthma	☐ Blood clots	☐ Lung disease

☐ Other medical conditions that affect your bones or joints:

☐ Substance abuse/drug addiction

☐ **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

Any blood thinners? Aspirin Plavix Coumadin NSAIDs Others

Please list ALL previous surgeries: If yes, name of surgeon and date
☐ Neck
☐ Back
☐ Others:
☐ **NONE**

Falls in last year? ☐ Yes ☐ No
Explain: ______________________________________
____

Are there any illnesses that run in your family? ☐ Rheumatologic disorders ☐ Cancer ☐ Bleeding disorders ☐ Heart problems ☐ Diabetes ☐ Other:

Do you live alone? ☐ Yes ☐ No
Do you take care of other family members? ☐ Yes ☐ No

What is your highest level of education? ______________________________________

** 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	☐ Paralysis
☐ Bleeding problems	☐ Loss of appetite	☐ Depression or mania	☐ Multiple Fractures
☐ Chest pain or palpitations	☐ Chronic vomiting	☐ Memory Loss	☐ Bowel/bladder dysfunction
☐ Foot & leg swelling	☐ Chronic diarrhea	☐ Insomnia	
☐ Constipation	☐ Osteoporosis	☐ Anxiety	

☐ **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: ☐ SITTING ☐ STANDING ☐ WALKING ☐ BENDING ☐ LYING DOWN

MY SYMPTOMS WORSEN WITH: ☐ SITTING ☐ STANDING ☐ WALKING ☐ BENDING ☐ LYING DOWN

IS YOUR PAIN ASSOCIATED WITH: ☐ BOWEL/BLADDER PROBLEMS; WHERE: ________________ ☐ NUMBNESS/TINGLING; WHERE: ________________
☐ WEAKNESS; WHERE: ________________ ☐ SKIN COLOR/TEMPERATURE CHANGES; WHERE: ________________

HAVE YOU BEEN TREATED ELSEWHERE? ☐ NO ☐ YES

WHERE:

BY WHOM:

X-RAYS TAKEN: ☐ NO ☐ YES;
WHEN:
WHERE:

MRI OR CT SCAN: ☐ NO ☐ YES;
WHEN:
WHERE:

NERVE STUDIES: ☐ NO ☐ YES;
WHEN:
WHERE:

PREVIOUS TREATMENTS:

☐ PHYSICAL THERAPY
☐ OCCUPATIONAL THERAPY
☐ CHIROPRACTOR
☐ EPIDURAL/INJECTION
☐ INJECTIONS, HOW MANY: _____
☐ ACUPUNCTURE
☐ PAIN SPECIALIST
☐ PSYCHOLOGIST
☐ BIOFEEDBACK/RELAXATION THERAPY
☐ STEROIDS / CORTISONE BY MOUTH
☐ TENS
☐ ICE/HEAT
☐ SPLINTS / BRACES
☐ MASSAGE
☐ ANTI-INFLAMMATORY MEDICATIONS: IBUPROFEN/MOTRIN, NAPROXEN/ALEVE, CELEBREX, MOBIC, ETC. ☐ **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
O O O O

ACHE
_ _ _ _ _

R L L R

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

0 2 4 6 8 10

WHAT IS YOUR AVERAGE PAIN LEVEL?
____

WHAT IS YOUR PAIN LEVEL AT BEST?
____

WHAT IS YOUR PAIN LEVEL AT WORST?
____

PATIENT SIGNATURE

DATE

PHYSICIAN SIGNATURE

DATE