New Patient Information and History Form

John K. Dorman, M.D., FACS

Diplomate of
The American Board of
Neurological Surgery

400 Rosalind Redfern
Grover Parkway
Suite 200
Midland, TX 79701
432 687-2350

8050 E. Hwy 191
Suite 212
Odessa, TX 79765
432 580-4700

General Information

Date:___________________________

Name:____
Last *First* *Middle*

Address:____
Street *City* *State* *Zip Code*

Social Security Number:_____________________________ Date of Birth:_____________________________

Gender: Male Female

Marital Statu: Single Married Widowed Divorced

Home Phone________________________________ Cell Phone_______________________________________

Work Phone________________________________ Fax____

Email Address:____

Employment Information

Are you Employed? Yes No

Employer Name:____

Employer's Address:____

Occupation:____

Contact Information

Spouse/Parent/Guardian Name:____

Emergency Contact Name (if different than above):_______________________________

Emergency Contact's Phone Number:____

Referring Physician:____

Family Physician (if different than above):_______________________________________

How did you hear about us?

Family Physician Friend Family Phone Book Internet

Other________________________

Insurance Information

Primary Insurance Company:____

Name of Policy Holder:____

Date of Birth:____________________ Social Security Number:____________________

Relationship to Patient: Self Spouse Parent

Policy Holder's Employer:____

Secondary Insurance Company:____

Name of Policy Holder:____

Date of Birth:____________________ Social Security Number:____________________

Relationship to Patient: Self Spouse Parent

Policy Holder's Employer:____

Workman's Compensation Information

You May Skip This Section If You Are Not Applying For Workman's Compensation

Claim #:____________________ Date of Injury:____________________

Name of Employer:____

Employer Address:____

Employer Phone #:____________________Supervison:____________________

Name of Insurance:____

Insurance Mailing Address:____

Claims Adjuster's Name:____

Claims Adjuster's Phone #:____________________ Ext:____________________

Treating Physician:____________________ Phone #:____________________

ASSIGNMENT OF INSURANCE BENEFITS: *Patients with insurance please read and sign below.*
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. John K. Dorman. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNATURE:____ **DATE:**______________________

Medical History

Reason For Visit: My area of pain or complaint(s) is/are:___________________________________
____
____

What part of your body is experiencing the greatest pain?____
____
____

Location of pain:______________________ Rate the pain from 0 (*none*) to 10 (*unbearable*):__________
Location of pain:______________________ Rate the pain from 0 (*none*) to 10 (*unbearable*):__________
Location of pain:______________________ Rate the pain from 0 (*none*) to 10 (*unbearable*):__________

☐ Sudden since___________ ☐ Gradually since__________ ☐ Following an injury on____________

☐ No prior low back pain ☐ No prior neck pain
☐ History of low back pain for _____ years ☐ History of neck pain for _____ years

Mid to Low Back
Pain quality: ☐ aching ☐ sharp ☐ burning ☐ cramping ☐ stabbing
Pain location: ☐ middle of low back ☐ to left ☐ to right ☐ across buttock/back

Neck
Pain quality: ☐ aching ☐ sharp ☐ burning ☐ cramping ☐ stabbing
Pain location: ☐ midline ☐ left side of neck ☐ right side of neck

Dominate hand: ☐ Left ☐ Right

What prior treatment(s) have you had for your symptoms?

- ☐ Physical therapy
- ☐ Chiropractic manipulations
- ☐ Epidural steroid injections
- ☐ Brace
- ☐ Bed rest

What activities make the pain *worse*? (Please check all that apply):

☐ sitting ☐ walking ☐ standing
☐ lying down ☐ lifting ☐ coughing
☐ sneezing ☐ bending forward ☐ bending backward
☐ other (explain):______________________________

What activities *reduce* the pain? (Please check all that apply):

☐ sitting ☐ walking ☐ standing
☐ lying down ☐ other (explain):______________________________

Are there any activities you are ***unable*** to do because of your pain?

☐ Dress without assistance ☐ Walk around the mall ☐ Go out socially
☐ Rake leaves ☐ Carry a laundry basket ☐ Fix a meal
☐ Make a bed ☐ Push a lawnmower ☐ Grocery shop
☐ Vacuum ☐ Lift ☐ Sports

Check if you have ***increased*** pain with any of the following:

☐ lifting ☐ housework ☐ mopping/sweeping ☐ bending over

If walking causes pain, how far can you walk before pain starts?

☐ pain is immediate ☐ ½ block ☐ 1 block ☐ 2-3 blocks ☐ other

Is walking pain relieved by sitting? ☐ YES ☐ NO

Do you have morning stiffness relieved by exercise? ☐ YES ☐ NO

Have you missed any work due to your pain? ☐ YES ☐ NO

If yes, what date did you last work?______________________________

Have you had any diagnostic studies:

☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Myelogram ☐ Discogram ☐ EMG

Previous Spine Surgery:

DATE	SURGEON	REASON FOR SURGERY	DID SURGERY HELP?	HOW LONG WAS IT EFFECTIVE
1.				
2.				
3.				

Allergies: List any medications you are allergic to and the reaction you have:_______________________

___

___

Medications: List all medications you are now taking and what they are for. *Be sure to include all over-the-counter medications.* **Please print clearly**:_______________________

___

___

___

___

Past Hospitalizations/ Surgical History:

Check any previous ***SPINAL*** surgeries and when they were performed:

☐ None ☐ Lumbar____________ ☐ Cervical____________ ☐ Thoracic____________

Other surgeries:

☐ None ☐ appendectomy ☐ cardiac surgery ☐ tonsil/adenoidectomy
☐ wisdom teeth removal ☐ gallbladder surgery ☐ thyroid surgery ☐ other orthopedic surgery
☐ breast surgery ☐ hernia repair ☐ Cesarean section ☐ other, *please list*: ________________

___

Injuries:_______________________________________

___

Review of Systems Check any item that applies to you.

Musculoskeletal/Joints: ☐ muscular disease ☐ arthritis ☐ other_______________________

Neurological: ☐ headaches ☐ migraines ☐ seizures/epilepsy ☐ strokes
☐ other_______________________

Metabolic: ☐ diabetes ☐ thyroid problems ☐ other_______________________

Bleeding Problems: ☐ anemia ☐ blood clots ☐ bleeding problems

Urinary: ☐ blood in urine ☐ frequent urination ☐ trouble starting urination
☐ trouble stopping urination ☐ pain with urination ☐ prostate disease
☐ kidney disease ☐ other________________________________

Respiratory: ☐ asthma ☐ bronchitis ☐ COPD ☐ emphysema ☐ pneumonia
☐ tuberculosis

Cardiovascular: ☐ chest pain ☐ mitral valve prolapse ☐ irregular heartbeats
☐ high blood pressure ☐ shortness of breath ☐ other:______________

Reproductive: ☐ infections ☐ herpes ☐ venereal disease

Gastrointestinal: ☐ stomach ulcers ☐ gallbladder problems ☐ pancreatitis ☐ colitis
☐ blood in stool ☐ hiatal hernia ☐ liver disease ☐ constipation ☐ hepatitis
☐ jaundice ☐ other________________________________

Cancer: ☐ lung ☐ breast ☐ colon/intestinal ☐ stomach ☐ prostate ☐ skin
☐ kidney ☐ bone ☐ other________________________________

Immunological Disease: ☐ HIV infections/AIDS

Ob/Gyn

☐ endometriosis ☐ osteoporosis ☐ post-menopausal

Are you on the pill? ☐ YES ☐ NO

Are you pregnant now? ☐ YES ☐ NO If yes, date due:____________________________

How long ago was your last complete physical examination? ________ years ________ months

Were there any abnormal findings? ☐ YES ☐ NO If yes, describe:________________________

____

____

Other Medical History

Do you smoke NOW? ☐ No ☐ Yes: Packs per day:_______ for _______ years

Did you smoke in the PAST? ☐ No ☐ Yes: Packs per day:_______ for _______ years

Do you drink alcoholic beverages? ☐ No ☐ Yes: Drinks per week:_______ for _______ years

Do you have a history of drug abuse? ☐ No ☐ Yes: Please describe____________________

Family History: Please check any of the problems your immediate family have had and indicate the family member.

☐ Diabetes________________________ ☐ Heart Disease________________________________

☐ Vascular Disease__________________ ☐ Cancer________________________________

☐ Neck Pain________________________ ☐ High Blood Pressure__________________________

☐ Low Blood Pressure_________________ ☐ Other__________________________________

Authorization For Release of Medical Information

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS

In accordance with Federal government privacy rule implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to severity of your medical condition, the law stipulated that this rule may be waived.

_______ **I DO NOT** authorize the practice to release any or all information concerning my medical care to any individual except as set forth above.

_______ **I DO** authorize the practice to verbally release any or all information concerning my medical care to the following:

Name:________________________________ Relationship to Patient:__________________________

Name:________________________________ Relationship to Patient:__________________________

I hereby certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

____ ________________________________

Patient Signature **Date**