SCRANTON ORTHOPAEDIC SPECIALISTS P.C.

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DATE: ____________________

Dear __________________________

Thank you for choosing our orthopaedic practice. This letter is a reminder of your upcoming appointment with Dr. __________________ on ____________________ at ____________.

In order to expedite the registration process, we ask you to bring the following:

1. All insurance information (Insurance cards). Also, bring Photo ID
2. If this is a Compensation injury, your Workmen's Comp Claim # and your Compensation Carrier address and phone number.
3. If Auto Accident related, your claim # and address and phone # or carrier.
4. A REFERRAL if you are a managed care participant. (Note: We are NOT allowed to see you if you do not have a referral form from your primary care physician.)
5. Please arrive 15 minutes early to complete paperwork.

We ask you to bring the actual films or copies of X-RAYS, MRI'S, BONE SCANS AND CAT SCANS AS WELL AS THEIR REPORTS, and any other pertinent test results.

If you were seen by another physician for the same problem, we ask that you hand carry any previous records, hospital records (operative reports) and any other reports (for example, nerve conduction studies, vascular studies). Please include any information regarding cortisone or epidural injections.

Enclosed is a history form (health questionnaire). Please bring the completed form with you to your appointment as well as the Authorization Form on the reverse of this page. Please bring an up to date list of your medications from your family doctor.

Payment is due at the time of service for co-payments and non-covered charges. We accept Mastercard, Visa and personal checks. If payment cannot be made at time of service, arrangements must be made with the Business Office at 307-1768 before your visit.

Directions to our office: Exit 190 off Route 81, make right, office is .3 miles on right.

Thank you for your cooperation. We look forward to meeting you.

Shoulder and Elbow Intake Form

Please circle or fill in completely

Patient Demographics

Name: ______________________________ Age: _______ Sex: M F

Occupation: _________________________ Height: ______ Weight: ______

RIGHT-HANDED LEFT-HANDED BOTH

Referring Physician: ____

Address (line 1): ____

Address (line 2): ____

Medical Complaint:

RIGHT SHOULDER LEFT SHOULDER RIGHT ELBOW LEFT ELBOW

Duration of symptoms: _______ DAYS WEEKS MONTHS YEARS

Are symptoms the result of an injury? YES NO

If yes, date and type of injury: ____________________________

Have you tried medication(s) (e.g., motrin, Tylenol)? YES NO

If yes, which medications? ____________________________

If yes, is medication helpful? YES NO

Have you tried physical therapy: YES NO

If yes, duration of therapy: ____________________________

If yes, was therapy helpful? YES NO

Have you had any injections? YES NO

If yes, how many and when? ____________________________

If yes, how long did the injection(s) help? _________ DAYS WEEKS MONTHS

Have you had an MRI of the symptomatic shoulder/elbow? YES NO

Will the pain wake you from a sound sleep? YES NO

Have you had previous problems, injuries, or surgery on the symptomatic shoulder/elbow? YES NO

If yes, when and what? ____________________________

What specific activities cause your symptoms?

SCRANTON ORTHOPAEDIC SPECIALISTS P.C.

HISTORY (Page 1)

Name: ______________________ **Today's Date:** ________

Address: ______________________ City ____________, State _____ Zip ______

Phone: Home _______ **Cell** _______ **Work** ______

SS#: ______________ **Date of Birth:** ________ **Age:** ________ **Sex** _____

Language spoken ______________ **Race/Ethnicity** ______________

Referring MD or Person: ____________ **Send Report?** ____ **Family MD:** ____________ **Send Report?** ____

CHIEF COMPLAINT

Why are you seeing the doctor today? ______________________

Current problem is the resultof a(n): Check all that apply
_____ **Car Accident** _____ **Work accident** _____ **Accident** ____**Other** ____________

If work accident, describe: ______________________ **Date of injury** ______

Job Title: ______________ **Hand Dominance:** ______________
Present Work Status: _____ **Working** _____ **Not Working** _____ **Light Duty**

Past Medical History (List any prior and current illnesses & injuries such as high blood pressure, diabetes, heart problems, cancer etc ______________________

____

____

____

Prior Surgery and hospitalizations, describe, year, complications: ______________________

____

____

____

Have you ever had general anesthesia: **No** **Yes**
Have any problems with anesthesia: **No** **Yes** **Describe:** ______________________

Please list medication you are taking at present and the dosage below:

Medication	Dose	Medication	Dose

I HAVE NO KNOWN ALLERGIES ☐

ALLERGIES: Please list:

____

____

Reviewed by: ______________________ MD Date: __________

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HISTORY (Page 2)

Name: ________________________________ **Today's Date:** __________

Family History
Parents ages and health (if deceased, age at death and cause) describe
____
____
____

Siblings sex, ages and health (if deceased, age at death and cause)
describe____
____
____

Family history of (circle if yes) Arthritis, Heart disease, Endocrine disease, Muscular disease, Diabetes, other, describe:
____
____
____

Social History
_____ Employed (occupation)______________ _____ Work in the home _____ Student
_____ Single _____ Married _____ Divorced _____ Separated _____Widowed
Children No Yes# _____
Do you live alone: No Yes
Exercise _____ Daily _____ Weekly _____ Monthly _____ Rarely _____Never
What type of exercise____
Are you on a special diet: No Yes Describe:______________________________
History of substance abuse: No Yes What? ___________________________
SMOKING: Current smoker ☐ Smoke every day ☐ Smoke some days ☐ ____ packs/day
Former smoker ☐ Never smoked ☐
Drink alcohol: _____ Daily _____ 1-2X week _____ 1-2X month _____ 1/2x year

Review of Systems
Are you currently having or have you had problems with your:

	Circle		Describe all Yes responses
Eyes	**No**	**Yes**	______________________
Ears, Nose, Throat	**No**	**Yes**	______________________
Lungs, Breathing	**No**	**Yes**	______________________
Digestion, Stomach problems	**No**	**Yes**	______________________
Bowel movements	**No**	**Yes**	______________________
Bladder problem	**No**	**Yes**	______________________
Heart Problems	**No**	**Yes**	______________________
Appetite or Weight Change	**No**	**Yes**	______________________
Bleeding problems	**No**	**Yes**	______________________
Balance problems	**No**	**Yes**	______________________
Numbness/tingling	**No**	**Yes**	______________________
Joint aches/pains	**No**	**Yes**	______________________
Depression, anxiety etc.	**No**	**Yes**	______________________
Epilepsy/seizures	**No**	**Yes**	______________________
AIDS	**No**	**Yes**	______________________

I certify that the above information is true and correct. Signed ________________________ Date ____

Reviewed by: ____MD Date ______________