Thunder Basin Orthopaedics and Sports Medicine

Mark G. Murphy, MD * Joseph F. Allegretto, MD
Robert J. Woodruff, MD * Dan A. Nicholls, PA-C * Tristyn Richendifer, PA-C

Today's Date:_____

Patient's Legal Name:_____ Date of Birth:_____

☐**o known allergies or drug allergies (please check when none are known)**

Allergies:	**Type of Reaction: (i.e. hives, nausea)**

*****Do you have a Latex allergy? ☐ YES ☐ NO**

Why are you seeing the doctor today? ☐ Left ☐ Right ☐ Both _____(body part)

Is this visit for an injury? ☐ Yes ☐No **DATE of Injury:_____** Time of Day:_____am pm

Where were you when the injury occurred?_____

How did the injury occur? (Please be as specific as possible.)_____
_____
_____

Current problem is the result of a(n): (Check all that apply)

C☐ Accident ***Work ☐Accident**Accident ☐ Other_____☐_____

***If a result of a work accident, have you filed a claim with Workers' Comp? ☐Yes ☐ No**

***Out of state Workers' Compensation patients will be responsible for any remaining balance not covered by their Workers' Comp.**
If you are claiming Workers' Comp for Wyoming or any other state, please initial that you understand the above statement. _____

Brief description of the symptoms you are experiencing (i.e. pain, popping, swelling)_____

Current Medications:(Please include Herbal Supplements and Vitamins)

Medications:	**Dose:**	**How Long?**	**Side Effects:**

Have you ever had general anesthesia? YESN☐ ☐
Have you ever had problems with general anesthesia? ☐ YES ☐ NO (Describe):_____
Any personal or family history of malignant hyperthermia? YESNO ☐ ☐

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~ Patient Information and Consent ~

Please complete this entire form and present your insurance card when registering.

Last Name _____ First Name _____ MI _____

Mailing Address _____ City_____ State _____ Zip _____

Physical Address _____ City_____ State _____ Zip _____

Phone: _____Cell_____ DOB _____ Age ____ Sex ____

Email _____

Marital Status _____ Social Security Number _____ Student ☐ Yes ☐ No

Primary Physician _____ Pharmacy Preference _____

How did you hear about us? _____

Referred by _____

Emergency contact not living with you _____ Phone _____

Patient's Employer

Employer _____ ☐ Full Time ☐ Part Time

Occupation _____

Address _____

City_____State _____ Zip _____ Phone _____

Guarantor Information—Person Responsible for Medical Expenses

Name_____ Relationship _____

Social Security Number _____ Date of Birth _____ Phone _____

Mailing Address: _____

City_____State _____ Zip _____ Phone _____

Employer _____ ☐ Full Time ☐ Part Time

Employer Phone _____

Primary Insurance

Company _____

Address: _____ City_____ State _____ Zip _____

Phone _____ Policy # _____ Group #_____

Policy Holder _____ DOB _____

Other Insurance

Company _____

Address: _____ City_____ State _____ Zip _____

Phone _____ Policy # _____ Group #_____

Policy Holder _____ DOB _____

I give the medical staff of Thunder Basin Orthopaedics permission to examine me and make recommendations while under their medical care.

_____

Signature Relationship to Patient Date

☐ Please do not discuss my medical information with anyone except myself.

☐ I give Thunder Basin Orthopaedics permission to give information on my medical condition and treatment to:

_____ Relationship _____

☐ I give permission to my employer to attend my office visit(s).

☐ I give TBO permission to give information and medical documentation to my employer.

_____

Signature Patient Name Date

I acknowledge that I have been given a written copy of Thunder Basin Orthopaedics& Sports Medicine's privacy policies regarding my personal health information.

_____

Signature Relationship to Patient Date

I have read, understand, and agree to the attached Financial Policy. I understand that the charges not covered by my insurance company, as well as applicable co-payment and deductible are my responsibility.

_____

Signature Patient Name Date

I attest that the information that I have given is correct and true to the best of my knowledge. I hereby assign benefits to Thunder Basin Orthopaedics& Sports and authorize them to furnish health information regarding me to my insurance carrier. I understand that I am responsible for any amount not paid by my insurance.

_____

Signature Relationship to Patient Date

THUNDER BASIN ORTHOPAEDICS & SPORTS MEDICINE

Policy Regarding Narcotic Medications

Welcome to TBO to all new patients; for all existing patients, thank you for your support and patronage for the past several years. Because of newer and stricter guidelines, imposed by the state of Wyoming and the Wyoming State Pharmacy Board, regarding the prescription use of narcotics and the documentation thereof, the physicians and other providers at TBO are compelled to provide this list of guidelines for your understanding and compliance.

1. TBO is an orthopaedic clinic facility, not an emergency room, pain clinic, or provider of urgent care. Patients are seen on a scheduled basis, but a referral is not necessary. If you have a physician who is managing your pain issues, he/she will continue to do so and you will need to advise us of this upon completion of initial paperwork. TBO will send a copy of our office notes and recommendations to that physician if you request.

2. The narcotic medications will be prescribed for **Severe Pain Issues Only**. These include patients who have suffered fractures or dislocations, undergone surgery, or have been involved recently (less than 3 months) in an acute trauma. The patient should provide the date and/or documentation of this trauma.

3. Refills for narcotic medications must be requested prior to 3 p.m., Monday through Thursday, excluding holidays. The physicians will review this request upon notice within 48 hours during the week. **In other words, you should call for a refill at least 48 hours before your supply runs out.** If you call for a refill on a Friday, it is probable that your request will not be addressed until the following Tuesday.

4. Drug seeking behavior, either documented or suspected by the physician, may be grounds for immediate restriction of all narcotic prescriptions from TBO. This behavior includes, but is not limited to: Calling after-hours for narcotic refills; receiving simultaneous narcotic prescriptions from physicians other than the staff at TBO; failure to comply with substitute, non-narcotic medications or therapies; failure to notify the physician of previous narcotic dependence/addiction; and taking pain medication in excess of the prescribed dose and regimen.

5. Refills will **NOT** be given in the case of "lost", stolen, inadvertently flushed, or otherwise destroyed medications. **Please Keep Your Prescription and/or Medication In A Safe or Otherwise Restricted Area.**

6. Under no circumstances will TBO refill narcotic medications longer than **three months**. If further narcotic management is deemed necessary—either by the patient or the physician, a referral to a pain clinic or pain management specialist will be made.

7. Benefits of the narcotic medication will be evaluated regularly using the following criteria: increase in general function, increase in life activities, improvement in pain intensity levels, possible return to work and maintenance of a job.

I, _____, have read, understand, and will comply with all of the guidelines listed above concerning narcotic medications.

_____ _____

Patient Signature Date

You as the patient have the right to request a copy of this signed agreement at any time

Cervical Initial History Form

Who referred you?
_____

When did your symptoms start?
_____

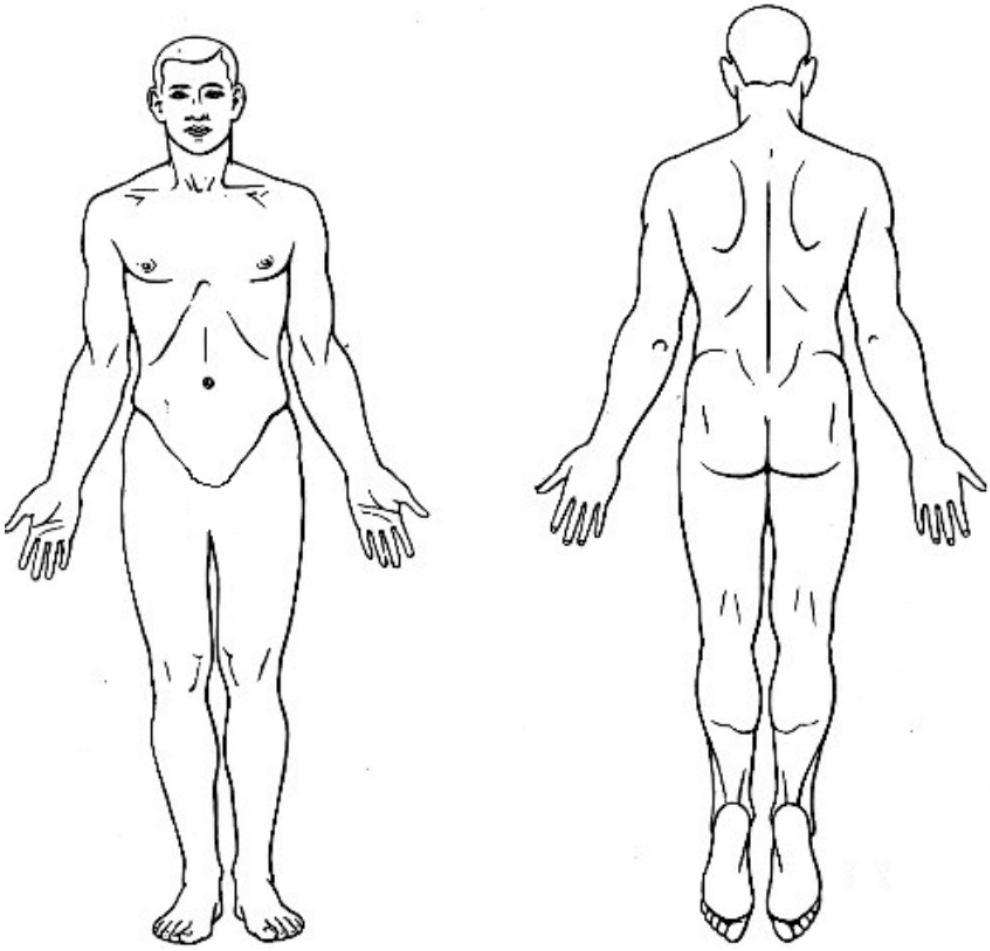
How did they start (MVA, fall, woke up with pain, etc.)?

_____
_____

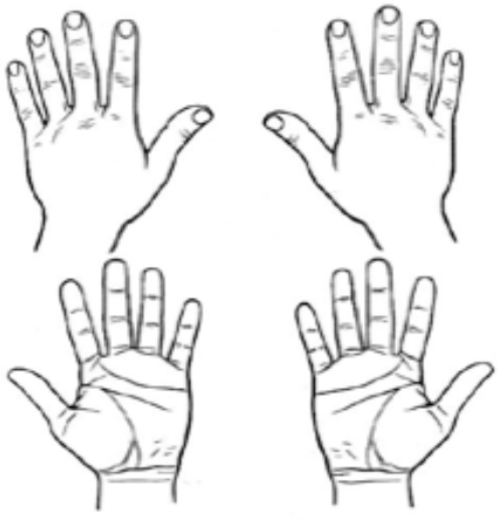
_____
_____

Do you smoke or chew tobacco? ___ Y ___ N How much?
_____

Use the following symbols to indicate on the diagrams the location and type of your symptoms.



XXXXXXX	Sharp / Stabbing
^^^^^^^	Numbness
**********	Pins and Needles
00000000	Ache (Dull)
////////	Burning



Circle the numbers that most accurately describe your pain level.

No Pain *Unbearable pain*

On average 0----1----2----3----4----5----6----7----8----9----10

At its worst 0----1----2----3----4----5----6----7----8----9----10

My symptoms are worse when I:

___ Looking up ___ Looking down___ Twisting ___ Lifting ___ Sitting___ Driving ___ Walking ___ Standing

___ Housework ___ Lying down ___ Other: _____

My symptoms are better when I:

___ Looking up ___ Looking down___ Twisting ___ Lifting ___ Sitting___ Driving ___ Walking ___ Standing

___ Housework ___ Lying down ___ Other: _____

I have tried:

___ Physical Therapy ___ Chiropractor ___ Heat ___ Ice ___ Massage ___ Traction ___ Acupuncture

___ Ibuprofen ___ Aleve ___ Meloxicam ___ Celebrex ___ Naproxen ___ Aspirin ___ Motrin ___ Diclofenac

___ Tylenol ___ Topicals ___ Flexeril ___ Baclofen ____ Robaxin ___ Hydrocodone ___ Oxycodone

___ Tramadol ___ Gabapentin ___ Lyrica

___ Other: _____

___ Epidurals (Location and Dates _____)

___ Other injections (Types _____)

Previous spinal surgeries (Date/Procedure/Surgeon)

_____

_____

_____

Other symptoms:

___ Fever ___ Chills ___ Nausea/Vomiting ___ Sweating ___ Night pain ___ Weightloss ___ Weight gain

___ Bowel problems (constipation, loose stool, other) ___ Loss of urinary control (urgency, stress, other)

___ Unsteadiness with walking ___ Falling ___ Problems buttoning shirts ___ Changes in handwriting

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Review of Systems

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

Please mark only the symptoms you CURRENTLY are experiencing.
Mark all that apply ---- if no symptoms, please mark "NONE"

General		fever	weight gain	
	tiredness	fatigue	persistent infections	
	night sweats	weight loss	chills	NONE
Eyes	headache	blurred vision	eye pain	
	double vision	excessive tearing	glasses/contacts	NONE
Ear, Nose, & Throat	sinus pain	hearing loss	ear discharge	
	sleep apnea	seasonal allergies	oral ulcers	NONE
Cardiovascular	chest pain	shortness of breath	swelling hands/feet	
	calf pain	palpitations	elevated blood pressure	NONE
Respiratory				
	cough	difficulty breathing	chronic cough	
	difficulty breathing on exertion	wheezing	bloody sputum	NONE
Breast	breast mass	breast pain	nipple discharge	NONE
Gastrointestinal		constipation	hemorrhoids	
	nausea	chronic diarrhea	excessive gas	
	vomiting	abdominal pain	indigestion	
	change in bowel habits	bloody stool	heartburn	NONE
Female Genitourinary (women only)				
	urinary frequency	vaginal itch or burning	incontinence	
	urinary urgency	painful urination	pelvic pain	
	urination at night	absence of menstruation	blood in urine	
	change in bladder habits	menstrual irregularities	stress incontinence	NONE
Male Genitourinary (men only)				
	painful urination	urinary urgency	testicular pain	
	change in bladder habits	impotence	blood in urine	
	urination at night	discharge	difficulty with erection	
	urinary frequency	testicular mass	incontinence	NONE
Musculoskeletal		joint stiffness	joint redness	
		joint swelling	muscle pain	
	decreased range of motion	joint pain	muscle weakness	NONE
Skin	dryness	rash	new sore/lesion	
	bruising	hives	skin ulcer	NONE
Neurologic	fainting	numbness	trouble walking	
	decreased memory	incontinence stool	seizures	
	weakness of extremities	incontinence urine	headaches	NONE
Psychiatric	anxiety	panic attack	fearful	
	change in sleep pattern	depression	hallucinations	NONE
Endocrine			cold intolerance	
	hair changes	heat intolerance	thyroid problems	
	excessive urination	excessive thirst	sexual dysfunction	NONE
Heme/Lymphatic	anemia	abnormal bleeding	blood clots	
	easy bruising	excessive bleeding	prolonged bleeding	NONE

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Patient History

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

Social History

Do you have an Advanced Directive? (If yes, please provide a copy).
Yes No

What is your Height?

Height	
Feet	Inches
	0
	1
	2
3	3
4	4
5	5
6	6
7	7
	8
	9
	10
	11

What is your Weight?

Weight		
	Pounds	
	00	0
100	10	1
200	20	2
300	30	3
400	40	4
500	50	5
	60	6
	70	7
	80	8
	90	9

Marital Status
Single Married Separated Divorced Widowed

Student Status / Work Status
Part Time Full Time N/A

Do you Live Alone?
Yes No

Exercise
Do you exercise regularly?
Yes No
Type: Walking Running Jogging Weight Training Cycling Other
Frequency per week? 1 2 3 4 5 6 7

Tobacco Use
Do you currently use tobacco products?
Current (every day) Current (some days) Previous Never
How many packs per day do you (or did you) smoke?
Less than 1 1 2 3 4 Greater than 4
Do you currently use other tobacco products?
Snuff Chewing Tobacco Pipe Cigar

Recreational / Street Drug Use
Yes No
Type? Marijuana Cocaine Crack-cocaine Heroin Methamphetamine IV Drug
How frequent? Daily Weekly Monthly Yearly

Alcohol Use
Yes No
How frequent? Occasional Moderate Heavy Quit

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Patient / Family History

Please answer every question

YOUR Medical History

Please indicate if **YOU** have a history of the following:

- Alcohol Abuse
- Anaphylaxis
- Anemia
- Anesthetic Complication
- Anxiety Disorder
- Arthritis
- Asthma
- Autoimmune Problems
- Birth Defects
- Bladder Problems
- Bleeding Disease
- Blood Clots / DVT
- Blood Transfusion(s)
- Bowel Disease
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Depression
- Diabetes
- Growth / Development Disorder
- Heart Attack
- Heart Disease
- Heart Pain / Angina
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- HIV
- Hives
- Joint Dislocations
- Kidney Disease
- Liver Cancer
- Liver Disease
- Loose Joints
- Lung / Respiratory Disease
- Lung Cancer
- Major Traumatic Injury
- Marfan's syndrome
- Mental Illness
- Migraines
- MRSA Infection or Colonization
- Osteoporosis
- Polio
- Prostate Cancer
- Rectal Cancer
- Seizures / Convulsions
- Severe Allergy
- Sexually Transmitted Disease
- Skin Cancer
- Steroid Use
- Steven-Johnson Syndrome
- Stroke
- Suicide Attempt
- TB (Tuberculosis)
- Thyroid Problems
- Ulcer
- Other Disease, Cancer, or Significant Medical Illness
- NONE of the Above

FAMILY Medical History

Please indicate if **YOUR FAMILY** have a history of the following:
(ONLY include parents, grandparents, siblings, and children)

- Family History Unknown
- Alcohol Abuse
- Anaphylaxis
- Anemia
- Anesthetic Complication
- Arthritis
- Asthma
- Bladder Problems
- Bleeding Disease
- Blood Clots / DVT
- Breast Cancer
- Colon Cancer
- Depression
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Lung / Respiratory Disease
- Migraines
- Osteoporosis
- Rectal Cancer
- Seizures / Convulsions
- Severe Allergy
- Steven-Johnson Syndrome
- Stroke
- Thyroid Problems
- Other Cancer
- NONE of the Above

- Mother, Grandmother, or Sister developed heart disease before the age of 65
- Father, Grandfather, or Brother developed heart disease before the age of 65

If you or your family member have been diagnosed with any other illness / disease not listed on this sheet, please notify your healthcare professional at the time of your appointment.

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Surgical History

Please answer every question

Surgical History

Please mark all surgeries you have had

◯ **I have had no Surgeries.**

◯ **Anal Fissure Repair**	◯ **Sinus Surgery**	◯ **Vasectomy**	◯ **Deviated Nose Septum**
◯ **Appendectomy**	◯ **Tonsillectomy**	◯ **Tubal Ligation**	◯ **Abdominal Surgery**
◯ **Hemorrhoidectomy**	◯ **Ulcer Surgery**		

Prostate Surgery	◯ TURP	◯ Removal		
Gallbladder Surgery	◯ Open	◯ Laparoscopic		
Colon Polyp Removal	◯ Open	◯ Colonoscopy		
Colon Removal	◯ Partial	◯ Complete		
Hysterectomy (due to cancer)	◯ Partial	◯ Complete		
Hysterectomy (not due to cancer)	◯ Partial	◯ Complete		
Spinal Fusion	◯ Neck	◯ Lower Back		
Spinal Decompression	◯ Neck	◯ Lower Back		
Dilation and Curettage (D&C)	◯ Single	◯ Multiple		
Lung Surgery	◯ Left	◯ Right	◯ Both	
Kidney Removal	◯ Left	◯ Right	◯ Both	
Cataract Surgery	◯ Left	◯ Right	◯ Both	
Breast Cancer Lump Removal	◯ Left	◯ Right	◯ Both	
Mastectomy	◯ Left	◯ Right	◯ Both	
Mastoidectomy	◯ Left	◯ Right	◯ Both	
Breast Reconstruction	◯ Left	◯ Right	◯ Both	
Breast Reduction	◯ Left	◯ Right	◯ Both	
Ovary Removal	◯ Left	◯ Right	◯ Both	
Hand	◯ Left	◯ Right	◯ Both	
Wrist	◯ Left	◯ Right	◯ Both	
Carpal Tunnel Surgery	◯ Left	◯ Right	◯ Both	
Elbow	◯ Left	◯ Right	◯ Both	
Arm	◯ Left	◯ Right	◯ Both	
Shoulder	◯ Left	◯ Right	◯ Both	
Rotator Cuff Repair	◯ Left	◯ Right	◯ Both	
Arthroscopic Shoulder Surgery	◯ Left	◯ Right	◯ Both	
Neck	◯ Left	◯ Right	◯ Both	
Back	◯ Left	◯ Right	◯ Both	
Hip	◯ Left	◯ Right	◯ Both	
Hip Fracture & Surgery	◯ Left	◯ Right	◯ Both	
Total Hip Replacement	◯ Left	◯ Right	◯ Both	
Leg	◯ Left	◯ Right	◯ Both	
Leg Circulation Surgery	◯ Left	◯ Right	◯ Both	
Knee	◯ Left	◯ Right	◯ Both	
Total Knee Replacement	◯ Left	◯ Right	◯ Both	
Arthroscopic Knee Surgery	◯ Left	◯ Right	◯ Both	
Ankle	◯ Left	◯ Right	◯ Both	
Foot	◯ Left	◯ Right	◯ Both	
Thyroid Removal	◯ Left	◯ Right	◯ Total	
Carotid Artery Surgery	◯ Left	◯ Right	◯ Both	
Open Inguinal Hernia Surgery	◯ Left	◯ Right	◯ Both	
Laparoscopic Inguinal Hernia Surgery	◯ Left	◯ Right	◯ Both	
Caesarean Section	◯ 1	◯ 2	◯ 3 or more	
Heart Valve Replacement	◯ Mitral	◯ Aortic	◯ Tricuspid	◯ Unknown Valve
Heart Bypass Surgery	◯ 1 vessel	◯ 2 vessels	◯ 3 vessels	
	◯ Unknown number of vessels			

If you have previously had any other surgeries not listed on this sheet, please notify your healthcare professional at the time of your appointment.