Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

Twin Cities Orthopedics Intake Form

Do you have a primary care physician?	Were you referred by a physician?
☐ No ☐ Yes – Please list the MD: Name: _____ Clinic: _____ Address: _____ _____	☐ No ☐ Yes – Please list the MD: Name: _____ Clinic: _____ Address: _____ _____

Preferred Pharmacy – Name: _____
Address: _____
_____

Medical History

Please indicate if you have a history of or currently have any of the following:

	Active	Past		Active	Past		Active	Past
Abnormal Rhythm	☐	☐	Emphysema	☐	☐	Osteoporosis	☐	☐
AIDS/HIV	☐		Factor V Leiden	☐	☐	Oxygen Dependence	☐	☐
Alcohol Abuse/Alcoholism	☐	☐	Fibromyalgia	☐	☐	Pacemaker – Heart	☐	☐
Arthritis: Osteoarthritis	☐	☐	Gallbladder disease	☐	☐	Polio	☐	☐
Arthritis: Rheumatoid	☐	☐	Gout	☐	☐	Pregnant Currently	☐	
Arthritis: Youth	☐	☐	Heart Attack		☐	Psoriasis	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐	Psychiatric Disorder	☐	☐
Bleeding Disorders	☐	☐	Hiatal Hernia	☐	☐	Recreational Drug Use	☐	☐
Blood Clots	☐	☐	High Blood Pressure	☐	☐	Reflux/GERD	☐	☐
Bone Infection	☐	☐	High Cholesterol	☐	☐	Renal Failure	☐	
Bronchitis	☐	☐	Irritable Bowel Syndrome	☐	☐	RSD	☐	☐
Cancer	☐	☐	Keloid Scar	☐	☐	Scoliosis	☐	
Claustrophobia	☐	☐	Kidney Disease	☐	☐	Seizures		☐
COPD	☐	☐	Liver Disease	☐	☐	Spinal Stenosis	☐	☐
Crohn's Disease	☐	☐	Lupus	☐	☐	Sprains/Ligament Injury	☐	☐
Delayed Wound Healing	☐	☐	Lyme Disease	☐	☐	Stomach Ulcers	☐	☐
Dementia	☐	☐	Malignant Hyperthermia	☐	☐	Stroke	☐	☐
Depression	☐	☐	MRSA	☐	☐	Substance Abuse	☐	☐
Diabetes	☐	☐	Multiple Sclerosis	☐	☐	Thyroid Disease	☐	☐
Difficulty with Anesthesia	☐	☐	Neuropathy	☐	☐	**NO SIGNIFICANT MEDICAL HISTORY** ☐		

OTHER SIGNIFICANT DISEASE (please specify active or past)**:**

Virtual Spine Consultation Request

Provided that your most recent study is less than 18 months old, Dr. Dick will review your neck and back MRI, CT scans and/or plain x-rays and discuss them with you over the telephone or via video conference.

Please print this Virtual Spine Consultation Request and the relevant Cervical or Lumbar Spine Pre Treatment Form. Fill them out completely. Enclose copies of your studies on a CD (the CDs will not be returned) and mail them to:

Jeffrey C. Dick, MD
Virtual Spine Consultation
Twin Cities Orthopedics
4010 West 65th Street
Edina, MN 55435

Or
Scan and email the forms to:
tierneysisk@tcomn.com
(CDs will still have to be sent via mail)

Name & Address

_____

_____

_____

Day/Evening Phone & Extensions:

_____

Best time to call (circle one):

Morning Afternoon Evening

By signing this form you agree that:

- **Your personally identifiable health care information can be shared with Dr. Dick and employees of Twin Cities Orthopedics.**
- **The Virtual Spine Consultation is for preliminary information only and is not a substitute for the more thorough evaluation that occurs during an in person appointment. Dr. Dick will make treatment recommendations but cannot prescribe treatments, medications or schedule surgery without an in person appointment.**
- **A written evaluation can only be provided during an in person appointment.**
- **There is a $99 charge for this service that is not covered by your insurance.**

I understand and agree to the above terms and conditions and request a Virtual Spine Consultation for informational purposes only.

Signature:_____ **Date:**_____

TWIN CITIES ORTHOPEDICS

Spine Questionnaire

Date:_____

Patient Name: _____ Referred By: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

What is the reason you are seeing the orthopedic surgeon (check all that apply):

☐ Surgery ☐ Non-surgical treatment ☐ 2nd opinion ☐ Disability rating.

History of Current Problems

Date that your neck or back problems started? _____

Have you had a similar problem in the past? ☐ No ☐ Yes. If yes, when? _____

Please describe: _____

Is your current problem the result of: ☐ No injury that you know of ☐ Work injury

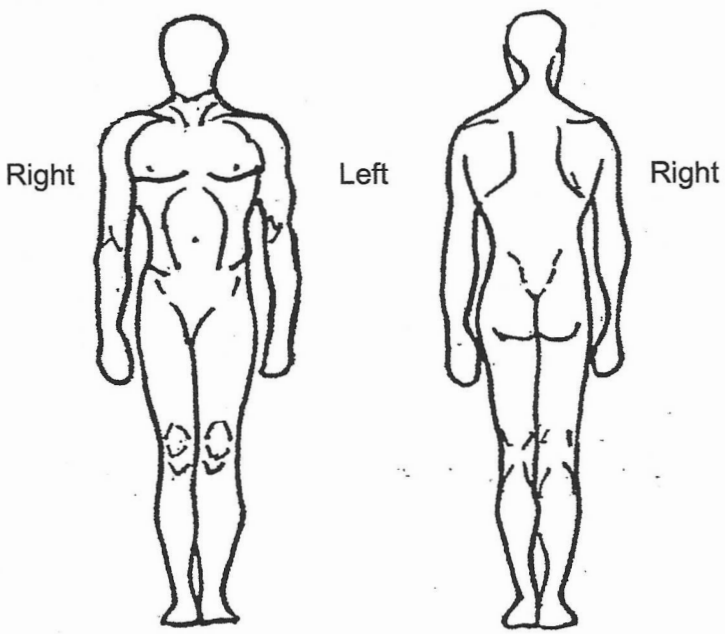
☐ Motor vehicle accident ☐ Other injury If an injury, give **the date:** _____

Has litigation or claim for compensation been initiated? ☐ No ☐ Yes

Please briefly describe how your current back/neck and/or leg/arm problems first began: _____

_____.

Symptom (Pain) Diagram – Please use the diagrams below to indicate the areas in which you are experiencing symptoms. Include all affected areas. Leave blank if your condition is not painful or symptomatic.



How much of your problem is back or leg? **Back**_____% + **Leg** _____% = **100%**

How much of your problem is neck or arm? **Neck**_____% + **Arm** _____% = **100%**

Treatment

What medications are you currently taking for pain? _____

_____

What medications have you taken in the past for pain?_____

_____

List the physicians that you have seen for this problem: _____

_____

How many times have you been treated by he following professionals?

Physical Therapist: _____. When? _____. Chiropractor: _____. When? _____.

Have you had any of the following treatments?

☐ Epidural Steroid Injections ☐ Trigger-Point Injections ☐ Facet Injections ☐ Other: _____

When? _____. When? _____. When? _____. When? _____

Please list any and all surgeries you have had on your spine:

Date	Surgeon	Procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check any of the following studies you have had and give the approximate date they were last done.

☐ X-Ray _____ ☐ CT Scan _____

☐ MRI Scan _____ ☐ EMG Test _____

☐ Discogram _____ ☐ Others _____

Work/Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Children: ☐ Yes ☐ No How many? _____ Ages _____

Do you live ☐ alone ☐ with family ☐ assisted living ☐ nursing home ☐ other_____.

Occupation_____ Employer_____ How long? _____

Are you currently working? ☐ Yes ☐ No If no, when did you last work? _____

Is your regular work? ☐ Heavy ☐ Medium ☐ Light ☐ Sedentary.

Are you currently on any work restrictions? ☐ Yes ☐ No If yes, what are they? _____

_____

How far do you estimate you can walk? _____ City blocks or _____ Miles, or ☐ Unlimited

Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

Surgical History								
Aneurysm Repair	☐			Hysterectomy	☐		
Ankle/Foot/Toe Related	Left	Right	Both	Kidney Stone	☐		
Ankle	☐	☐	☐	Knee Related	Left	Right	Both
Foot/Toe	☐	☐	☐	ACL Surgery	☐	☐	☐
Appendectomy	☐			Scope/Arthroscopy	☐	☐	☐
Bladder surgery	☐			Partial Knee Replacement	☐	☐	☐
Carotid Artery	☐			Total Knee Replacement	☐	☐	☐
C-Section	☐			Leg Circulation	Left ☐	Right ☐	Both ☐
Gallbladder Surgery	☐			Lung Surgery	Left ☐	Right ☐	Both ☐
Hand/Wrist/Finger Related	Left	Right	Both	Shoulder Related	Left	Right	Both
Carpal Tunnel	☐	☐	☐	Scope/Arthroscopy	☐	☐	☐
Wrist	☐	☐	☐	Rotator Cuff Repair	☐	☐	☐
Hand/Finger	☐	☐	☐	Total Shoulder Replacement	☐	☐	☐
Heart Related				Spine Related	Low Back	Neck	
Bypass Surgery	☐			Disc Low Back	☐	☐	
Pacemaker	☐			Spinal Decompression	☐	☐	
Implanted Defibrillator	☐			Spinal Fusion	☐	☐	
Stent	☐			Thyroidectomy	☐		
Valve Replacement	☐			Tonsillectomy	☐		
Hernia Surgery	☐			Ulcer	☐		
Hip Related	Left	Right	Both	Wisdom Teeth Removal	☐		
Scope/Arthroscopy	☐	☐	☐	**NO SURGICAL HISTORY**	☐		
Fracture/Pinning or Plate	☐	☐	☐	**OTHER SURGERY** (please specify)**:**			
Partial Hip Replacement	☐	☐	☐				
Total Hip Replacement	☐	☐	☐				

Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

Family History

Please indicate which family member(s) below have had these illnesses:

	Father	Mother	Brother	Sister	Son	Daughter	Grandfather		Grandmother	
							Maternal	Paternal	Maternal	Paternal
Arthritis: Osteoarthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis: Rheumatoid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder (e.g. Hemophilia, Clotting Problems, Anemia)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Difficulty with Anesthesia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Disease of Bones (e.g. Osteoporosis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Disease of Muscles (e.g. Fibromyalgia)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Disease of Nervous System (e.g. MS)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Infectious Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Disorder (e.g. Depression)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peripheral Vascular Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

NO SIGNIFICANT FAMILY MEDICAL HISTORY ☐

UNKNOWN FAMILY MEDICAL HISTORY ☐

OTHER FAMILY MEDICAL HISTORY (please specify illness and family member)**:**

Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

Review of Systems

Mark all that apply in each group. If no symptoms, please mark "none" for that category.

General Issues:

☐ NONE ☐ Chills ☐ Feeling poorly (malaise) ☐ Feeling tired
☐ Fever ☐ Night sweats ☐ Recent weight gain ☐ Recent weight loss

Other Issues:

☐ NONE ☐ Emotional Problems ☐ Stress ☐ Anxiety ☐ Sleep Disturbances

Cardiovascular:

☐ NONE ☐ Chest pain ☐ Cold hands or feet ☐ Generalized warmth of skin
☐ Heart rate is fast ☐ Heart rate is slow ☐ Leg cramping ☐ Limb swelling ☐ Palpitations

Skin:

☐ NONE ☐ Change in a mole ☐ Change in skin color ☐ Itching ☐ Psoriasis
☐ Redness ☐ Problems with healing wound ☐ Skin lesions ☐ Skin rash ☐ Skin wound

Ear, Nose & Throat:

☐ NONE ☐ Difficulty swallowing ☐ Hoarseness ☐ Loss of hearing
☐ Nose bleeds ☐ Sinus pains ☐ Wears hearing aid

Endocrine:

☐ NONE ☐ Excessive thirst ☐ Heat/cold intolerance ☐ Hot flashes

Eyes:

☐ NONE ☐ Visual disturbances ☐ Vision prescription

Urinary:

☐ NONE ☐ Blood in urine ☐ Incontinence ☐ Kidney disease
☐ Painful urination ☐ Pelvic pain

Stomach/Digestion:

☐ NONE ☐ Abdominal pain ☐ Bloody stools ☐ Constipation
☐ Diarrhea ☐ Difficulty swallowing ☐ Heartburn ☐ Nausea ☐ Vomiting

Hematologic/Lymphatic:

☐ NONE ☐ Easy bruising ☐ Easy bleeding

Muscle, Bone & Joint:

☐ NONE ☐ Back pain ☐ Decrease range of motion ☐ Joint locking
☐ Joint pain ☐ Joint stiffness ☐ Joint swelling ☐ Limb (arm) pain
☐ Limb (leg) pain ☐ Muscle pain ☐ Neck pain ☐ Shooting pain

Head & Balance:

☐ NONE ☐ Confusion ☐ Difficulty walking ☐ Dizziness
☐ Fainting ☐ Headache ☐ Limb weakness ☐ Numbness ☐ Tingling

Respiratory:

☐ NONE ☐ Cough ☐ Shortness of breath ☐ Shortness of breath on exertion ☐ Wheezing

Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

Medications

Are you currently taking any medications?

☐ No ☐ Yes – Please list all the medications you are currently taking (including vitamins and supplements):

- ➢
- ➢
- ➢
- ➢
- ➢
- ➢
- ➢
- ➢
- ➢
- ➢
- ➢
- ➢

Allergies

Medication Allergies

☐ **NO MEDICATION ALLERGIES**
☐ Acetaminophen (list reaction _____)
☐ Aspirin (list reaction _____)
☐ Augmentin (Amoxicillin) (list reaction _____)
☐ Celebrex (list reaction _____)
☐ Cephalosporins (Antibiotics) (list reaction _____)
☐ Cipro (Ciprofloxacin) (list reaction _____)
☐ Codeine (list reaction _____)
☐ Coumadin (list reaction _____)
☐ Demerol (list reaction _____)
☐ Doxycycline (list reaction _____)
☐ Erythromycin (Antibiotics) (list reaction _____)
☐ Flagyl (list reaction _____)
☐ Ibuprofen (list reaction _____)
☐ Iodine (list reaction _____)
☐ Keflex (list reaction _____)
☐ Levofloxacin/Levoquin (list reaction _____)
☐ Lidocaine (Xylacaine) (list reaction _____)
☐ Lovenox (list reaction _____)
☐ Morphine (list reaction _____)
☐ Naprosyn (Naproxen) (list reaction _____)
☐ Oxycodone (list reaction _____)
☐ Penicillin (list reaction _____)
☐ Prilosec (Omeprazole) (list reaction _____)
☐ Sulfa (list reaction _____)
☐ Tegretol (Carbamazepine) (list reaction _____)
☐ Tenormin (Atenolol) (list reaction _____)
☐ Tetanus Toxoid (list reaction _____)
☐ Tetracycline (list reaction _____)
☐ Valium/Diazepram (list reaction _____)
☐ Vancomycin (list reaction _____)
☐ Zirthomax (Azithromycin) (list reaction _____)
☐ **OTHER** (please also list reaction)**:**

Non-Medication Allergies

☐ **NO NON-MEDICATION ALLERGIES**
☐ Adhesive Tape (list reaction _____)
☐ Contrast Media (Contrast/Dye) (list reaction _____)
☐ Environmental/Seasonal (list reaction _____)
☐ Egg (list reaction _____)
☐ Latex (list reaction _____)
☐ Metal Allergy (list reaction _____)
☐ Peanuts/Tree Nuts (list reaction _____)
☐ Rubber (list reaction _____)
☐ Shellfish (list reaction _____)
☐ **OTHER** (please also list reaction)**:**

Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

Social History

1. Height: ____ feet ____ inches
2. Weight: _____ pounds
3. Gender: ☐ Male ☐ Female
4. Please select your age group:
   ☐ 0-13 (You may now skip to the "Federal Register" section on page 7)
   ☐ 14-17 (Please answer question 5 and then you may skip to the "Federal Register" section on page 7)
   ☐ 18-49
   ☐ 50-64
   ☐ 65+
5. Is your visit related to a work injury?
   ☐ No ☐ Yes – Please provide the following information:
   Employer name: _____
   What year did you start working with your employer?: _____
   Who is your Qualified Rehabilitation Consultant (QRC)? _____

THESE QUESTIONS ARE REQUIRED ONLY IF YOU ARE 18 YEARS OR OLDER:

6. Is your shirt collar 16 inches or larger (generally size L for female or XL for male shirt)?
   ☐ Yes ☐ No ☐ I don't know
7. Do you snore loudly?
   ☐ Yes ☐ No
8. Do you often feel tired, fatigued or sleepy during the daytime (falling asleep while driving)?
   ☐ Yes ☐ No
9. Has anyone observed you stop breathing or choking/gasping during your sleep?
   ☐ Yes ☐ No
10. Do you have a history of Vitamin D insufficiency?
    ☐ Yes ☐ No ☐ I'm not sure
11. Which of the answers below best describes your history of falling?
    ☐ I have fallen 2 or more times in the past year
    ☐ I am at risk for future falls
    ☐ I am not at risk of falling
12. Do you use tobacco (smoke, chew, etc.)?
    ☐ Never
    ☐ Yes – regularly or occasionally use tobacco
    ☐ Previously used tobacco but quit (how long ago did you stop using tobacco?: _____)
    ☐ Decline to answer

If you use tobacco (yes to question 12):

13. What types of tobacco do you use?
    ☐ Cigarettes/Cigars
    ☐ Other tobacco product(s) (chew, etc.)
14. How many years have you used tobacco?: _____
15. Do you consume alcohol?
    ☐ Yes ☐ Recovering alcoholic
    ☐ No ☐ Decline to answer
16. Do you exercise?
    ☐ Yes ☐ No
17. What is your current marital status?
    ☐ Single
    ☐ Married
    ☐ Domestic Partner
    ☐ Divorced
    ☐ Widowed
    ☐ Decline to answer
18. Do you have children?
    ☐ Yes
    ☐ No
19. Do you live:
    ☐ Alone
    ☐ With family
    ☐ Nursing home
    ☐ Assisted living
    ☐ Skilled nursing facility (name of skilled nursing facility: _____)
    ☐ Other
    ☐ Decline to answer

Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

Federal Register Questions
Do you consider yourself Hispanic/Latino? ☐ Yes ☐ No ☐ Decline to answer
What category best describes your race? (Identify all that apply) ☐ Asian ☐ Black or African American ☐ Hmong ☐ Native American ☐ Native Hawaiian or Other Pacific Islander ☐ Somali ☐ White ☐ Decline to answer

Thank you!

You have now completed the Twin Cities Orthopedics health history form.
Please bring your forms to the front desk.