PLEASE CHECK THE CONDITIONS WHICH YOU HAVE BEEN DIAGNOSED AS HAVING

- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BACK PROBLEMS
- ☐ BLADDER INFECTIONS
- ☐ BLEEDING DISORDER
- ☐ BLOOD CLOTS / DVT
- ☐ BLOOD TRANSFUSIONS
- ☐ BRONCHITIS
- ☐ CANCER _____
- ☐ CATARACTS
- ☐ CHICKEN POX
- ☐ CONGENITAL DEFORMITIES
- ☐ CONGESTIVE HEART FAILURE
- ☐ COPD / EMPHYSEMA
- ☐ CROHNS / ULCERATIVE COLITIS
- ☐ DEMENTIA
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIPHTHERIA
- ☐ DIVERTICULOSIS
- ☐ ECZEMA
- ☐ EPILEPSY / SEIZURES
- ☐ FIBROMYALGIA
- ☐ GERD / HEARTBURN
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEART ATTACK
- ☐ HEART DISEASE / CORONARY
- ☐ HEART MURMUR
- ☐ HEART PALPITATIONS
- ☐ HEART VALVE DISEASE
- ☐ HEMORRHOIDS
- ☐ HEPATITIS A / B / C
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV / AIDS
- ☐ HYPERTHYROID / HYPOTHYROID
- ☐ INFECTIOUS MONONUCLEOSIS
- ☐ INSOMNIA/ SLEEP DISORDER
- ☐ IRREGULAR HEART BEAT
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES
- ☐ LIVER DISEASE / CIRRHOSIS
- ☐ LOW BLOOD PRESSURE
- ☐ LUPUS
- ☐ MALARIA
- ☐ MEASLES
- ☐ MIGRAINE HEADACHES
- ☐ MITRAL VALVE PROLAPSE
- ☐ MUMPS
- ☐ NEUROLOGICAL DISEASE
- ☐ NEUROPATHY
- ☐ OSTEOPOROSIS
- ☐ PACEMAKER
- ☐ PANCREATITIS
- ☐ PARKINSON'S
- ☐ PEPTIC (STOMACH) ULCERS
- ☐ PERIPHERAL VASCULAR DISEASE
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PROSTATE ENLARGEMENT
- ☐ PULMONARY EMBOLISM
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATOID ARTHRITIS
- ☐ SCARLET FEVER
- ☐ SEASONAL ALLERGIES
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ SHINGLES
- ☐ SLEEP APNEA
- ☐ SMALLPOX
- ☐ STROKE / TIA
- ☐ TUBERCULOSIS
- ☐ URINARY INCONTINENCE
- ☐ VERTIGO
- ☐ WHOOPING COUGH
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

PLEASE CHECK / LIST ALL SURGERIES

- ☐ APPENDIX
- ☐ CATARACT
- ☐ GALL BLADDER
- ☐ HERNIA REPAIR
- ☐ TONSILS / ADENOIDS
- ☐ WISDOM TEETH
- ☐ CESAREAN SECTION
- ☐ HYSTERECTOMY
- ☐ TUBAL LIGATION
- ☐ CARDIAC STENTS / ANGIOPLASTY
- ☐ CARDIAC BYPASS
- ☐ CARDIAC CATHERIZATION
- ☐ PACEMAKER
- ☐ COLONOSCOPY
- ☐ PROSTATE
- ☐ BLADDER SUSPENSION
- ☐ GASTRIC BYPASS
- ☐ COSMETIC
- ☐ NECK / CERVICAL SPINE
- ☐ BACK / LUMBAR SPINE
- ☐ R / L ANKLE / FOOT
- ☐ R / L KNEE
- ☐ R / L HIP
- ☐ R / L SHOULDER
- ☐ R / L ELBOW
- ☐ R / L WRIST
- ☐ R / L HAND / FINGER
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

MEDICATIONS & SUPPLEMENTS

	DRUG NAME	DOSE	FREQUENCY (HOW OFTEN)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

ALLERGIES

		REACTION THAT OCCURS
☐	**NO KNOWN ALLERGIES**	
☐	LATEX / TAPE / ADHESIVES	
☐	PENICILLIN	
☐	SULFA DRUGS	
☐	CODEINE	
☐	IODINE / BETADINE	
☐	SHELLFISH / EGGS / AVIAN (BIRD)	
☐	CONTRAST DYE	
☐	_____	
☐	_____	
☐	_____	
☐	_____	

FAMILY MEDICAL HISTORY

	AGE	CONDITIONS OR DISEASES	IF DECEASED, CAUSE OF DEATH
FATHER			
MOTHER			
SIBLING			
SIBLING			

MARITAL STATUS	USE OF ALCOHOL	TOBACCO	LIVING SITUATION
☐ SINGLE	☐ NEVER	☐ NEVER	☐ WITH FAMILY
☐ MARRIED	☐ RARELY	☐ PREVIOUS, BUT QUIT	☐ WITH FRIENDS
☐ DIVORCED	☐ MODERATE	☐ CURRENT	☐ ALONE
☐ WIDOWED	☐ FREQUENTLY	_____PACKS PER DAY	☐ ASSISTED LIVING
☐ SEPARATED	☐ DAILY	_____# OF YEARS	☐ OTHER

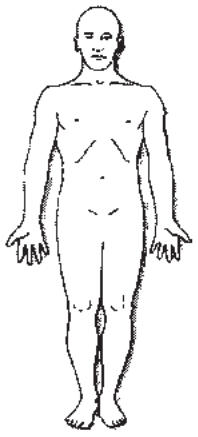
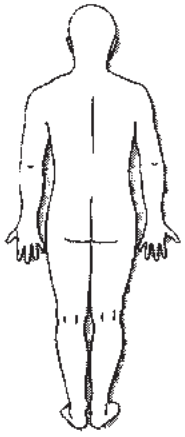
REVIEW OF SYSTEMS: PLEASE CHECK EITHER "YES" OR "NO"

	NO	YES
RECENT ILLNESS		
UNEXPLAINED WEIGHT CHANGE		
CHANGE IN APPETITE		
FEVER		
FATIGUE		
GLASSES / CONTACT LENSES		
CHANGE IN VISION		
HEARING DIFFICULTY		
HEARING AIDS		
RINGING IN EARS		
NOSEBLEED / GUMS BLEED		
DENTURES		
DIFFICULTY SWALLOWING		
CHRONIC COUGH		
SHORTNESS OF BREATH		
FAINTING		
CHEST PAIN AT REST		
CHEST PAIN WITH EXERCISE		

	NO	YES
FOOT / ANKLE SWELLING		
ABNORMAL EKG		
ABNORMAL CHEST XRAY		
STOMACH PAIN		
NAUSEA / VOMITING		
DIARRHEA		
CONSTIPATION		
BLOOD IN STOOL		
BLOOD IN URINE		
JOINT SWELLING		
MUSCLE WEAKNESS		
HEADACHES / DIZZINESS		
EXCESSIVE THIRST		
BRUISE EASILY		
SKIN RASHES OR SORES		
NUMBNESS / TINGLING OF HANDS		
NUMBNESS / TINGLING OF FEET		
HAVE YOU HAD DIFFICULTY WITH ANESTHESIA?		

SIGNATURE OF PATIENT OR PARENT OF MINOR DATE

SIGNATURE OF PHYSICIAN DATE

PATIENT NAME: FIRST LAST	GENDER: ☐ M ☐ F	DATE OF VISIT:
OCCUPATION:		
☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED	HEIGHT:	WEIGHT:
WHO REFERRED YOU TO AKSC?		
WERE YOU REFERRED BY ANOTHER PHYSICIAN? ☐ YES ☐ NO	PLEASE LIST YOUR PRIMARY PHYSICIAN INFORMATION BELOW	
NAME:	NAME:	
SPECIALTY:	CITY/STATE:	
CITY:	PHONE:	
REASON FOR VISIT: ☐ RIGHT ☐ LEFT ☐ BOTH _____	DOMINANT ARM: ☐ RIGHT ☐ LEFT	
WHEN DID SYMPTOMS BEGIN?		
PLEASE DESCRIBE ANY INJURY AND LOCATION IT OCCURRED:		
HAVE YOU STOPPED WORKING DUE TO AN INJURY? ☐ YES ☐ NO WHEN? / /		
HAVE YOU REPORTED THE INJURY? ☐ YES ☐ NO	ARE YOU WORKING WITH RESTRICTIONS? ☐ YES ☐ NO	
COURSE OF PROBLEM ☐ IMPROVING ☐ WORSENING ☐ NO CHANGE		
DESCRIBE SYMPTOMS ☐ SHARP ☐ STABBING ☐ TEARING ☐ DULL ☐ ACHY ☐ THROBBING ☐ OTHER _____		
ASSOCIATED SYMPTOMS ☐ CATCHING ☐ CLICKING ☐ LOCKING ☐ SWELLING ☐ GIVING WAY/BUCKLING ☐ POPPING ☐ STIFFNESS ☐ GRINDING ☐ WEAKNESS ☐ NUMBNESS ☐ TINGLING ☐ OTHER _____		
WHEN DO YOU EXPERIENCE SYMPTOMS? ☐ OCCASIONALLY ☐ FREQUENTLY ☐ CONSTANTLY ☐ WITH ACTIVITY ☐ AT REST ☐ MORNING ☐ DAYTIME ☐ EVENING ☐ NIGHTTIME ☐ WHILE ASLEEP		
WHAT MAKES THE PROBLEM WORSE?		
WHAT MAKES THE PROBLEM BETTER?	PLEASE MARK " ● " WHERE YOU HAVE SYMPTOMS	
CIRCLE YOUR PAIN ON THE FOLLOWING SCALES "0" = NO PAIN "10" = DISABLING AT REST 0 1 2 3 4 5 6 7 8 9 10 AT WORST 0 1 2 3 4 5 6 7 8 9 10		
WHAT TREATMENT HAVE YOU HAD? ☐ NONE ☐ PHYSICAL THERAPY ☐ CORTISONE INJECTIONS ☐ HYALURONIC ACID INJECTIONS ☐ MASSAGE THERAPY ☐ ACUPUNCTURE ☐ MEDICATIONS _____ ☐ BRACE ☐ CASTING ☐ CHIROPRACTIC ☐ OTHER _____		
RESULTS OF TREATMENT? ☐ IMPROVED ☐ WORSENED ☐ NO CHANGE		
HAVE YOU HAD DIAGNOSTIC TESTS? ☐ X-RAYS ☐ MRI ☐ CT SCAN ☐ BONE SCAN ☐ EMG ☐ OTHER _____		
HAVE YOU HAD SURGERY FOR THIS PROBLEM? WHEN LOCATION SURGEON OUTCOME		

PATIENT INFORMATION RECORD

ATLANTA KNEE & SHOULDER

RAJ D. PANDYA, M.D.
FRANK CHEVRES, M.D.
GREGORY H. LEE, M.D.

Last Name: _____ First: _____ Middle Initial & Suffix _____

Sex: ☐ Female ☐ Male Previous Last Name _____ Age _____ Date of Birth _____/_____/_____ Race _____

SSN: _____ Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Patient Status: (circle all that apply) Married Single Divorced Widow Homebound Retired Disabled Student

Type of Injury: ☐ Work ☐ Auto ☐ Sports ☐ Other _____ Injury Date _____

(For Injuries at Work - Please Complete Additional Paperwork. We will not file Motor Vehicle Insurance)

How Did You Hear About Us: Primary Doctor - ER - Friend - Web Site - Another Patient - Insurance Directory

(Please circle all that apply) School Contact - Hospital - Yellow Page Ads - Other _____

Guardian Last Name: _____ First: _____ Middle Initial & Suffix _____

Emergency Contact Name: _____ Phone: (____) _____ Relationship _____

(Not living in same household)

Employer/School _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Employer/School Address: _____ Phone (____)_____

Guarantor/Insured's Last Name: _____ First: _____ Middle Initial & Suffix _____

Guarantor Address if Different From Patient: _____

Zip Code: _____ City: _____ State: _____

SSN: _____ Date of Birth _____/_____/_____ Employer: _____

Employer Address: _____ Phone: (_____)_____

Insurance Information-Primary Insurance Company Name _____

Is this a group policy through your employer: Yes_____ No_____ Group Number: _____

Policy Holders Name: _____ Date of Birth _____/_____/_____ SS#: _____

Insurance ID Number/Contract Number: _____ Date: _____

Patient's relationship to insured: _____ Office Visit Co-pay: $_____

Will you be paying co-pays and deductibles by: Cash _____ Check _____ Credit Card _____ (MC, VISA, AMEX, DISC)

Insurance Information-Second (#2) Insurance Company Name _____

Is this a group policy through your employer: Yes_____ No_____ Group Number: _____

Policy Holders Name: _____ Date of Birth _____/_____/_____ SS#: _____

Insurance ID Number/Contract Number: _____ Effective Date: _____

Patient's relationship to insured: _____ Office Visit Co-pay: $_____

Will you be paying co-pays and deductibles by: Cash _____ Check _____ Credit Card _____ (MC, VISA, AMEX, DISC)

I_____, hereby authorize Atlanta Knee and Shoulder or its physicians to furnish information to insurance carriers concerning my present illness/injury and treatment. I assign all payments for medical services rendered to myself or to my dependents directly to the physician(s) as a result of this claim. I understand that I am personally and financially responsible for payment of all services rendered regardless of insurance coverage.

Date: _____ Signature: _____ Payment is expected at the time of the Visit.