

Paul V. Spiegl M.D., / Tedman L. Vance, M.D.

Patient Intake questionnaire

PLEASE PRINT

Patient Name: _____ Date: _____

*Date of Birth: _____ *Gender: _____ Appointment Date: _____

*Race/Ethnicity: _____ Asian/Pacific Islander _____ Caucasian/White _____ Black/African American
_____ Arab Americans _____ American Indian/Alaska Native _____ Hispanic/Latino _____ Other

*Preferred Language: _____

How were you referred to Dr. Spiegl or Dr. Vance?

- Worker's Compensation Attorney Referral – Name of Attorney: _____
- Liability Attorney Referral - Name of Attorney: _____
- Patient Referral - Name of Patient _____
- Physician Referral - Name of Physician _____
- Hospital Referral – Name of Hospital: _____
- Online Advertisement
- Other: _____

MEDICAL HISTORY:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Degenerative joint disease | <input type="checkbox"/> Juvenile rheumatoid arthritis | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> DVT | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Benign prostatic hypertrophy | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> SLE |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> GERD | <input type="checkbox"/> Obesity | <input type="checkbox"/> Spinal stenosis |
| <input type="checkbox"/> Cerebrovascular accident | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Spondyloarthropathy |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Valvular disease |

SURGICAL HISTORY:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ACL surgery | <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Small Bowel Resection |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> CABG | <input type="checkbox"/> Hip Arthroplasty | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Angio with stent | <input type="checkbox"/> Cardiac Valve Replacement | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Knee Replacement | |
| <input type="checkbox"/> Arthroscopy Ankle | <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Laminectomy | |
| <input type="checkbox"/> Arthroscopy Elbow | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> LASIK | |
| <input type="checkbox"/> Arthroscopy Hip | <input type="checkbox"/> Colectomy | <input type="checkbox"/> Meniscus Surgery | Gender Specific |
| <input type="checkbox"/> Arthroscopy Knee | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Muscle Biopsy | <input type="checkbox"/> Cesarean Section |
| <input type="checkbox"/> Arthroscopy Wrist | <input type="checkbox"/> Discectomy | <input type="checkbox"/> ORIF | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Arthroscopy Shoulder | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Mastectomy |

ADDITIONAL MEDICAL / SURGICAL HISTORY: (include right or left, year of surgery, or additional surgeries)

FAMILY HISTORY: (includes all illnesses and conditions, state of health, cause of death)

NO KNOWN FAMILY HISTORY

MOTHER: _____

FATHER: _____

SIBBLINGS: _____

SOCIAL HISTORY:

MARITAL STATUS _____ # OF CHILDREN _____ SONS _____ DAUGHTERS _____

OCCUPATION _____ EMPLOYMENT STATUS _____

*SMOKING Current Everyday Smoker Current Occasional Smoker Never Smoked Former Smoker

TYPE _____ PACKS PER DAY _____ # OF YEARS _____ YEAR QUIT _____

ALCOHOL YES NO FREQUENCY _____

CAFFEINE YES NO CHECK TYPE COFFEE/ SODA/ CHOCOLATE/ TEA

***ALLERGIES TO MEDICATION:**

NO KNOWN ALLERGIES

MEDICATION _____ BRAND _____ REACTION _____

MEDICATION _____ BRAND _____ REACTION _____

MEDICATION _____ BRAND _____ REACTION _____

***MEDICATIONS:**

NO MEDICATIONS

MEDICATION _____ DOSAGE _____ FREQUENCY _____

MEDICATION _____ DOSAGE _____ FREQUENCY _____

MEDICATION _____ DOSAGE _____ FREQUENCY _____

***PREFERRED PHARMACY:**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

NURSES DOCUMENTATION:

HEIGHT/FEET _____ INCHES _____ WEIGHT _____

CURRENT PHYSICIANS:

Primary Care _____

Cardiologist _____

Infectious Disease _____

Endocrinologist _____

Pulmonary Specialist _____