STRASBURGER ORTHOPAEDICS, PC
7121 Stephanie Lane, Suite 100
Lincoln, Nebraska 68516
402-466-0100

Scott E. Strasburger, MD
Jack Nickolite, PA-C
Melinda Okosun, PA-C

Patient Demographics and History Form

Today's Date _____

Name_____
First: Middle: Last:

AGE:_____**Date of Birth** (mm/dd/yyyy) _____Social Security #_____

Gender : □ Male □ Female
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Address_____
City_____**State**_____**Zip**_____

Phone: Home # _____**Cell #** _____
Work # _____ **E-mail Address** _____

Employment Status □ Employed □ Student □ Retired □ Unemployed
Employer Name _____Occupation _____
School Name_____

Primary Language Spoken
□ English □ Spanish □ Vietnamese □ Other_____

Emergency / Medical Contact Emergency
Contact Name_____
Contact Phone Number_____
Contact Relationship _____

Referral Source / Primary Care Physician
Primary Care Physician_____
Referring Physician_____

Insurance Information

Primary Insurance

Primary Insurance Company _____

Policy ID Number _____

Policy Group Number _____

Is the Patient the policy holder? □ Yes □ No

If no, your relationship to Primary Policy Holder_____

Name of Primary Policy Holder _____

DOB of Primary Policy Holder _____

Gender of Primary Policy Holder □ Male □ Female

Policy Holder's Social Security Number _____

Street Address of Primary Policy Holder _____

City_____ State_____ Zip Code_____

Secondary Insurance (if applicable)

Policy ID Number _____

Policy Group Number _____

Is the Patient the policy holder? □ Yes □ No

If no- Relationship to Primary Policy Holder _____

Name of Primary Policy Holder _____

Date of Birth of Primary Policy Holder _____

Gender of Primary Policy Holder □ Male □ Female

Policy Holder's Social Security Number _____

Address of Primary Policy Holder _____

City _____ State_____ Zip Code _____

Parent / Guardian Demographics (if patient is under 19)

Name _____

Phone _____ Cell Phone _____

Address (if different than above) _____

City _____ State _____ ZIP _____

Date of Birth _____SSN_____

Worker's Compensation / Liability Confirmation □ Yes □ No

If Yes-

Date of Injury _____Injured Body Part(s) _____

Worker's Compensation Employer _____

Worker's Compensation Contact Person at Employer _____

Worker's Compensation Employer Phone Number _____

Worker's Compensation / Liability Insurance _____

Worker's Compensation / Liability Insurance Phone _____

Worker's Compensation / Liability Claim Address _____

City_____ State_____ Zip Code_____

Worker's Compensation / Liability Claim Number _____

Worker's Compensation / Liability Insurance Adjuster _____

MEDICAL HISTORY FORM

Current Symptoms

Chief Complaint

Body Part_____

Date of Injury if applicable _____

Occurred:

□ Car Accident □ Fall □ Gradual Onset □ Sports / Recreational Injury

□ Unknown □ Other_____

Height:_____ _____**Weight:**_____ **Are you:** □ **Right handed** □ **Left handed**

Pain Scale: On a scale of 1-10, rate your pain level when it is at its worst (10 being worst)

0 1 2 3 4 5 6 7 8 9 10

Treatments / Tests since onset symptoms

□ Steroid Injection □ CT Scan / MRI □ Medication □ Physical Therapy

□ Surgery □ X-Ray □ Other / Not Listed □ None

Past Medical History

Past and Current Medical Conditions □ NONE

□ Abnormal Heart Rhythm □ Alcoholism □ Anemia □ Anorexia Bulimia

□ Anxiety □ Asthma □ Bleeding Disorders □ Blood Clots / DVT

□ Bronchitis □ Cancer □ Depression □ Diabetes

□ Emphysema □ Endometriosis □ Gout □ Heart Attack

□ Heart Failure □ Hepatitis □ High Blood Pressure □ HIV

□ Irritable Bowel □ Kidney Failure □ Kidney Stones □ Liver Disease

□ Lung Disease □ Osteoarthritis □ Osteoporosis □ Ovarian Cysts

□ Rheumatoid Arthritis □ Seizures □ Sleep Apnea □ Stents

□ Stomach Ulcers □ Stroke □ Thyroid Disease □ Tuberculosis

□ Other_____

Medications □ No Medications

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Preferred Pharmacy _____

Drug Allergies □ No Drug Allergies

□ Anti-seizure Medications □ Aspirin □ Codeine □ Contrast Dye

□ Demerol □ Depakote □ Dilantin □ Insulin

□ Iodine □ Latex □ Morphine □ Penicillin

□ Sulfa □ Other (List Below)

Drug Allergies Other

1. _____
2. _____
3. _____

Surgeries or Procedures □ No Previous Surgeries

□ Angioplasty □ Appendectomy □ Back Surgery □ Cardiac Stent / Catheterization

□ Cataract Surgery □ Cesarean Section □ Colon / Bowel Surgery □ Gastric Bypass

□ Hernia Repair □ Hysterectomy □ Joint Replacement □ Kidney Surgery

□ Neurosurgery □ Pacemaker Implantation □ Problems with Anesthesia in the past □ Thyroid Surgery / Biopsy

□ Other/Not Listed (List below)

Other Surgeries or Procedures and date

1. _____
2. _____
3. _____
4. _____

Review of Systems:

Are you experiencing any of the following? (Please circle all that apply)

General	Neurological	Cardiovascular	Gastrointestinal
Fever	Loss of balance	Chest pain	Nausea/vomiting
Chills	Frequent falls	Swelling of legs/ankles	Heartburn
Night Sweats	Dizziness	Rapid Heart Rate	Abdominal pain
Loss of appetite	Speech difficulties	Irregular heart beat	Blood in stools
Unexplained weight loss	Seizures/tremors		

Genitourinary	HENT	Respiratory	Eyes
Blood in urine	Frequent nose bleeds	Shortness of breath	Double vision
Frequent urinary infections	Difficulty swallowing	Coughing up blood	Sudden loss of vision
Painful urination	Chronic headaches	Persistent cough	

Skin	Psychiatric	Hematology	Endocrine
Rash	Depression	Swollen glands	Excessive thrist/hunger/urination
Itching	Anxiety	Easy bleeding/bruising	

Family Medical History

Cancer	□ Father	□ Mother	□ Brother	□ Sister
Diabetes	□ Father	□ Mother	□ Brother	□ Sister
Heart Disease	□ Father	□ Mother	□ Brother	□ Sister
Stroke	□ Father	□ Mother	□ Brother	□ Sister

□ Other _____ □ Unknown

Social History

Smoking Status

□ Current everyday □ Current some day □ Former □ Never

Alcohol Status

□ Current everyday □ Current some day □ Former □ Never

Exercise

□ Heavy amount of exercise (4 or more times per week)

□ Moderate amount of exercise (1-3 times a week)

□ Minimal exercise (1 time a week)

□ Active but no forma exercise

□ Never

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Receipt of Notice of Privacy Practices

I acknowledge that I was given the opportunity to receive a copy of Strasburger Orthopaedics, P.C, Notice of Privacy Practices.

_____
Printed Name

_____
Signature (must be signed by parent/legal guardian if patient is a minor)

_____
Date