



SEQUOIA ORTHOPAEDIC
& SPINE INSTITUTE, INC.
Frank L. Feng, D.O.

PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____

SS # _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PHONE (_____) _____

OCCUPATION _____

MALE ☐ FEMALE ☐ STUDENT: FULL ☐ PART TIME ☐

SINGLE ☐ MARRIED ☐ WIDOWED ☐

WHO CARRIES THE PRIMARY INSURANCE: _____

Email: _____

SPOUSE / PARENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____

SS # _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

EMPLOYER _____

ADDRESS _____

CITY _____

WORK PHONE (_____) _____

OCCUPATION _____

EMERGENCY CONTACT (_____) _____

DO YOU HAVE A COPAYMENT? ☐ YES ☐ NO AMOUNT: \$ _____

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

I HEREBY AUTHORIZE DIRECTLY TO SEQUOIA ORTHOPAEDIC & SPINE INSTITUTE, INC. ALL SURGICAL AND MEDICAL BENEFITS AND OTHERWISE PAYABLE TO ME FOR SERVICES PERFORMED. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

X SIGNED _____ RELATIONSHIP _____ DATE _____

*NOTE: Please notify us if any of the above information changes during the course of your treatment.

BILLING INFORMATION

(OFFICE USE ONLY)

PRIMARY INSURANCE

PLAN NAME _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

GROUP # _____

SUBSCRIBER # _____

EFFECTIVE DATE _____

INSURED NAME _____

SECONDARY INSURANCE

PLAN NAME _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

GROUP # _____

SUBSCRIBER # _____

EFFECTIVE DATE _____

INSURED NAME _____

DOI _____ BODY PART _____

WORKERS COMPENSATION INSURANCE INFORMATION

INSURANCE NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____

ADJUSTER _____

PHONE (_____) _____

FAX (_____) _____

NCM _____

PHONE (_____) _____

EMPLOYER AT TIME OF INJURY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____

DOI _____ CL # _____ BODY PART _____

DOI _____ CL # _____ BODY PART _____

INT. NEEDED? ☐ YES ☐ NO PHONE _____

NAME OF AGENCY _____

RECEPTIONIST INITIALS _____

SEQUOIA ORTHOPAEDIC & SPINE INSTITUTE, INC

MEDICAL QUESTIONNAIRE

Due to government requirements that physicians document complete information on each patient, we ask you to complete the following detailed form in its entirety. Should you have trouble with any of the questions, please feel free to ask our staff for assistance. Some of the information may be sensitive; rest assured that the staff of SOSI will keep this information confidential. Thank you for your cooperation.

I. PATIENT IDENTIFICATION

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Who is your primary / family doctor? _____

How were you referred to our office: ☐ Self ☐ ER (which one)? _____ ☐ Primary MD (name) _____

☐ Other (list name) _____ Height: _____ Weight: _____

Have you seen any other doctors in this office/group (whom)? _____

II. PRESENTING COMPLAINT / PROBLEM

Reason for visit: _____ Date of injury: _____

Cause of injury: _____ Where it occurred: _____

Work-related? ☐ YES ☐ NO Previous injury? _____

Previous studies? Where performed & date?

X-rays _____ MRI _____

CT scan _____ Bone scan _____

Other _____

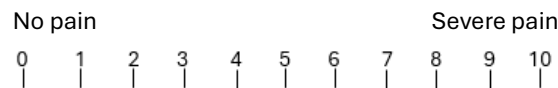
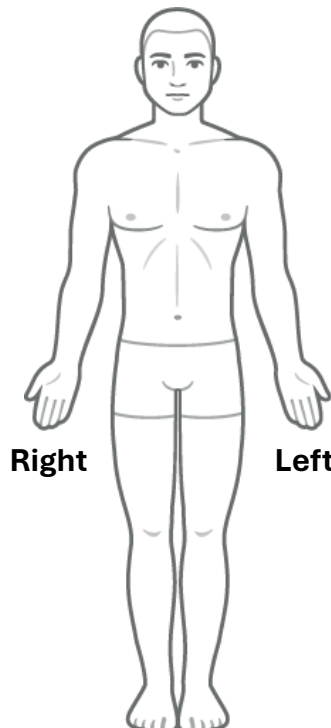
☐ Right-handed

☐ Left-handed

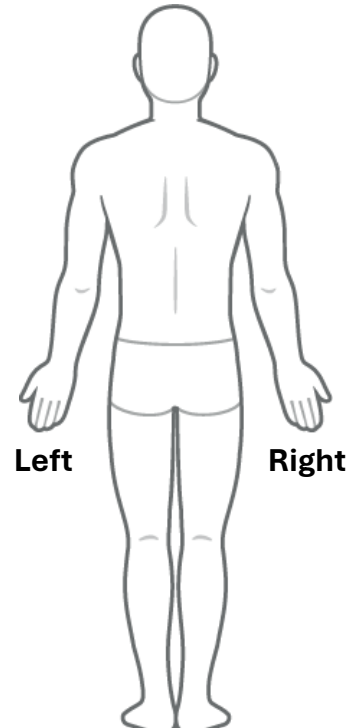
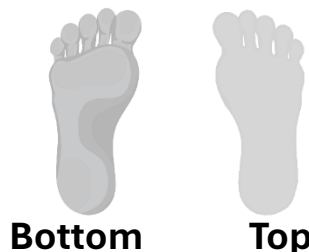
PAIN DRAWING

Be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness = = = = Pins & Needles ○○○○ Burning Pain x x x x Stabbing Pain /// Aching Pain (((



PAIN SCALE



III. MEDICAL HISTORY

CHECK YES or NO to indicate if you have EVER had any of the following disorders, and circle the appropriate condition.

General: Rheumatoid arthritis, cancer (where)? _____ ☐ YES ☐ NO

Eyes/Ears: Glaucoma, hearing loss ☐ YES ☐ NO

Neuro: Migraine headaches, seizures, epilepsy, stroke, polio, nerve injury ☐ YES ☐ NO

Endocrine: Diabetes, thyroid disorder, adrenal insufficiency ☐ YES ☐ NO

Cardiac: Coronary artery disease, angina, heart attack, arrhythmia, valve disease, rheumatic fever ☐ YES ☐ NO

Respiratory: Asthma, emphysema, tuberculosis ☐ YES ☐ NO

GI: Reflux/ulcer disease, liver disease/hepatitis, bowel disease ☐ YES ☐ NO

Vascular: High blood pressure, phlebitis, DVT/clot, anemia, bleeding disorder ☐ YES ☐ NO

Psych: Mental illness, depression, bipolar disorder ☐ YES ☐ NO

Other: Alcoholism, osteoarthritis, osteoporosis, AIDS, social drugs, _____ ☐ YES ☐ NO

Serious injury (where)? _____ ☐ YES ☐ NO

IV. PREVIOUS SURGERIES / HOSPITALIZATIONS – list all past surgeries and dates

V. MEDICATIONS – INCLUDE HERBAL SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS

MEDICATION	DOSE	# TIMES PER DAY	MEDICATION	DOSE	# TIMES PER DAY
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VI. ALLERGIES (DRUG REACTIONS)

Are you allergic to any drugs or have you had any reactions to medications? ☐ YES ☐ NO

If YES, LIST the drugs and the type of reaction: _____

VII. FAMILY HISTORY (biological grandparents, parents, siblings) – is there a family history of any serious medical conditions – such as diabetes, hypertension, heart disease, cancer?

☐ YES ☐ NO If YES, please explain: _____

VIII. SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children living: _____

Presently living alone? ☐ YES ☐ NO Stairs at home? ☐ YES ☐ NO Number of steps: _____

Occupation: _____ Still at work? ☐ YES ☐ NO If no, last date worked: _____

How long at present job? _____

Physical demands of work: ☐ Heavy ☐ Moderate ☐ Light ☐ Lifting ☐ Pushing ☐ Squatting ☐ Prolonged standing ☐ Sitting

Alcohol use: ☐ Never ☐ Rare ☐ Occasional ☐ Moderate ☐ Heavy ☐ Quit, how many years ago? _____

Tobacco use: ☐ Nonsmoker ☐ Smoker #packs per day _____ Years _____

☐ Previous smoker How many years ago? _____

Chew? ☐ YES ☐ NO

Drug use: ☐ YES ☐ NO ☐ PAST What type? _____

Sports/Exercise prior to injury? ☐ YES ☐ NO What type? _____

Number of times/week: _____ ☐ Recreational ☐ School/College level ☐ Semi/Professional

How has injury affected these activities? _____

IX. REVIEW OF SYSTEMS

General Health: ☐ Good ☐ Average ☐ Fair ☐ Poor

CHECK YES or NO to indicate if you have had any of the following symptoms, and circle the appropriate condition.

Unexplained weight loss, fatigue, fever, chills, sleep disturbances	☐ YES ☐ NO
Double vision, blurred vision, dizziness	☐ YES ☐ NO
Hearing loss, sinus infections, hoarseness, ringing in ears	☐ YES ☐ NO
Chest pain, palpitations, irregular heartbeat	☐ YES ☐ NO
Shortness of breath, productive cough, blood in sputum	☐ YES ☐ NO
Change in appetite, abdominal pain, constipation, diarrhea, vomiting blood, blood in stools	☐ YES ☐ NO
Incontinence, hesitancy, burning with urination, urinary frequency, blood in urine	☐ YES ☐ NO
Skin color changes, rashes, lesions, masses, skin ulcers	☐ YES ☐ NO
Difficulty swallowing, speaking, seizures, balance problems, changes in sensation, blackouts	☐ YES ☐ NO
Lethargy, anxiety, depression, nervousness, insomnia	☐ YES ☐ NO
Bruise easily, swollen glands, nosebleeds, gum bleeding	☐ YES ☐ NO
Prior blood transfusions, when? _____	☐ YES ☐ NO
Are you claustrophobic?	☐ YES ☐ NO
Do you have any metal in your body?	☐ YES ☐ NO
Other symptoms? Please specify: _____	

Patient signature

Date

I have reviewed this form and used the data in forming my opinion and making recommendations.

Physician's initials: _____ Date: _____

Physician's initials: _____ Date: _____

Physician's initials: _____ Date: _____

Physician's initials: _____ Date: _____

Physician's initials: _____ Date: _____

Physician's initials: _____ Date: _____