



NORTHEAST ORTHOPEDICS

And Sports Medicine Clinic

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"Keeping You In Motion"



**NORTHEAST ORTHOPEDICS & SPORTS CLINIC
PATIENT INFORMATION QUESTIONNAIRE**

DATE: _____

NAME: _____
LAST FIRST MIDDLE INITIAL NICKNAME

MARITAL STATUS: _____ SEX: M F AGE: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE HOME: () _____ WORK () _____ CELL () _____

SOC. SEC. # _____ EMERGENCY NAME: _____ PHONE: () _____

NAME OF SPOUSE/PARENT _____ EMPL: _____ PHONE: () _____

SOC. SEC. # OF SPOUSE/PARENT: _____

COMPLAINT: _____ Right () Left () SYMPTOM/ACCIDENT DATE: _____

HOW DID ACCIDENT HAPPEN? _____

_____ LOCATION: _____

PATIENT'S EMPLOYER/SCHOOL: _____ WERE X-RAYS TAKEN: YES NO

REFERRING COACH/ATHLETIC TRAINER: _____ REFERRING PHYSICIAN: _____

REFERRING FAMILY MEMBER/FRIEND: _____ FAMILY PHYSICIAN: _____

HOSPITAL PREFERENCE: _____

PRIMARY INSURANCE CO: _____ SECONDARY INSURANCE CO: _____

POLICY HOLDER: _____ POLICY HOLDER: _____

Relation to Patient: _____ Relation to Patient: _____

Date of Birth: _____ Date of Birth: _____

Insured Social Security #: _____ Insured Social Security #: _____

CO-PAY: _____ CO-PAY: _____

POLICY # _____ POLICY # _____

GROUP # _____ GROUP # _____

INSURANCE CARD HOLDER'S EMPLOYER: _____ INSURANCE CARD HOLDER'S EMPLOYER: _____

Name: _____ Name: _____

IS THIS A WORKMEN'S COMPENSATION CASE? NO YES If YES, fill in the following:

Date of Accident: _____ Date last worked: _____

Employer: _____ W/C Carrier: _____

Mailing Address: _____ Address: _____

City/State/Zip: _____

Appt. Date/Time: _____ ATTN: _____

Physician: _____ Phone: _____

Approved by: _____ Claim #: _____

I ACKNOWLEDGE THAT A COPY OF THE PRIVACY POLICIES OF NORTHEAST ORTHOPEDIC CLINIC, P.C. HAS BEEN MADE AVAILABLE TO ME. _____ (Initial)
 I hereby authorize Northeast Orthopedics and Sports Clinic (NEO) to furnish information to insurance carriers and any other medical providers rendering services to me under the direction of NEO concerning my illness and treatments rendered by NEO or such other medical providers, and hereby assign to NEO all payments for medical and/or surgical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance. I agree to pay all costs of collection, including a reasonable attorney's fee, should this account be placed with an attorney for collection. I waive all rights of exemption under the Constitution and the Laws of the State of Alabama.

Date: _____ Signature: _____

Relationship to Patient: _____ DOB: _____ SS#: _____

NORTHEAST ORTHOPEDIC

Medical / Surgical History

NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ D.O.B: _____
 (CIRCLE Y or N)

E.E.N.T

Y / N EYE INFECTIONS
 Y / N GLAUCOMA
 Y / N CATARACTS
 Y / N VISION CHANGES
 Y / N EAR OR HEARING PROBLEMS
 Y / N PAIN OR DIFFICULTY SWALLOWING
 OTHER: _____

CARDIOVASCULAR

Y / N HIGH BLOOD PRESSURE
 Y / N RHEUMATIC HEART DISEASE
 Y / N HEART ATTACK
 Y / N HEART FAILURE
 Y / N HEART MURMUR
 Y / N PACEMAKER
 OTHER: _____

SKELETAL

Y / N OSTEOARTHRITIS
 Y / N RHEUMATOID ARTHRITIS
 Y / N GOUT
 Y / N BROKEN BONES
 (LOCATION): _____
 OTHER: _____

LUNG

Y / N ASTHMA
 Y / N BRONCHITIS
 Y / N EMPHYSEMA
 Y / N PNEUMONIA
 Y / N TB
 Y / N BLOOD CLOT(S) IN LUNGS
 Y / N SLEEP APNEA
 OTHER: _____

GASTROINTESTINAL

Y / N ULCERS
 Y / N HIATAL HERNIA
 Y / N GALLSTONES
 Y / N DIVERTICULITIS
 Y / N HEPATITIS
 Y / N CIRRHOSIS
 OTHER: _____

SYSTEMATIC DISORDERS

Y / N DIABETES
 Y / N THYROID TROUBLE
 Y / N HIGH CHOLESTEROL
 Y / N ANEMIA
 Y / N SICKLE CELL
 Y / N BLEEDING TENDENCY
 Y / N CONVULSIONS
 Y / N STROKE
 Y / N MIGRAINE HEADACHES
 OTHER: _____

GENTOURINARY

Y / N KIDNEY INFECTIONS
 Y / N KIDNEY STONES
 Y / N PROSTATE TROUBLE
 Y / N VENEREAL DISEASE
 OTHER: _____

WEIGHT: _____ OCCUPATION: _____

SMOKE: YES _____ NO _____ PACKS/DAY: _____ ALCOHOL: YES _____ NO _____ OCCASIONALLY _____

OTHER: _____

OPERATIONS:

_____	DATE _____	_____	DATE _____
_____	DATE _____	_____	DATE _____
_____	DATE _____	_____	DATE _____
_____	DATE _____	_____	DATE _____

MEDICATIONS TAKEN REGULARLY: (please be specific)

_____ DOSE _____
 _____ DOSE _____
 _____ DOSE _____
 _____ DOSE _____
 _____ DOSE _____
 _____ DOSE _____

Prescribing Physician

KNOWN DRUG ALLERGIES:

MEDICATION LIST

Please list all medications you are presently taking, and circle the number of any that need refilled.

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

Pharmacy: _____ Phone: _____

	Name	Dose	Directions
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____
16.	_____	_____	_____

PLEASE KEEP THIS LIST WITH YOU AT ALL TIMES, KEEP UPDATED AND BRING TO EACH OFFICE VISIT.