

# GENERAL MEDICAL QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ FAMILY PHYSICIAN: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

REASON FOR VISIT TODAY: \_\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_

PAST OPERATIONS: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

PAST ILLNESSES: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

PAST FRACTURES: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

PRESENT HISTORY: Height \_\_\_\_\_ Weight \_\_\_\_\_

DO YOU SMOKE? YES ( ) NO ( ) If yes, how much? \_\_\_\_\_

DO YOU USE ALCOHOL? YES ( ) NO ( ) If yes, how much? \_\_\_\_\_

DO YOU TAKE ASPIRIN? YES ( ) NO ( ) If yes, how much? \_\_\_\_\_

DO YOU TAKE ANTI-INFLAMMATORY MEDICATION? YES ( ) NO ( ) If yes, how much? \_\_\_\_\_

(If yes to above medication, for what diagnosis? \_\_\_\_\_)

## ANY HISTORY OF THE FOLLOWING:

Asthma	YES ( )	NO ( )	Lung Disease	YES ( )	NO ( )
Diabetes	YES ( )	NO ( )	Heart Disease	YES ( )	NO ( )
Bleeding Problems	YES ( )	NO ( )	Gout	YES ( )	NO ( )
Stomach/Ulcer Problems	YES ( )	NO ( )	Liver Disease	YES ( )	NO ( )
High Blood Pressure	YES ( )	NO ( )	Kidney Disease	YES ( )	NO ( )
Thyroid Disease	YES ( )	NO ( )	Glaucoma	YES ( )	NO ( )
Sleep Apnea	YES ( )	NO ( )	Other	YES ( )	NO ( )
Arthritis	YES ( )	NO ( )			

If yes, where? \_\_\_\_\_ If known, what type? \_\_\_\_\_

## LIST ANY FAMILY MEMBER WITH HISTORY OF HEART OR LUNG DISEASE, CANCER OR SERIOUS ILLNESS:

RELATIONSHIP: \_\_\_\_\_ TYPE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ TYPE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ TYPE: \_\_\_\_\_

# MEDICAL HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PLACE AN (X) BEFORE ANY SYMPTOMS YOU HAVE NOW.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> fever, chills       | <input type="checkbox"/> palpitations           | <input type="checkbox"/> arthritis or joint pains     |
| <input type="checkbox"/> excess sweating     | <input type="checkbox"/> shortness of breath    | <input type="checkbox"/> nighttime urination          |
| <input type="checkbox"/> fatigue             | <input type="checkbox"/> swollen feet or ankles | <input type="checkbox"/> easy bruising or bleeding    |
| <input type="checkbox"/> trouble with vision | <input type="checkbox"/> high blood pressure    | <input type="checkbox"/> hot weather intolerance      |
| <input type="checkbox"/> eye pain or redness | <input type="checkbox"/> jaundice               | <input type="checkbox"/> cold weather intolerance     |
| <input type="checkbox"/> hearing trouble     | <input type="checkbox"/> heartburn              | <input type="checkbox"/> increased thirst             |
| <input type="checkbox"/> nose bleeds         | <input type="checkbox"/> difficulty swallowing  | <input type="checkbox"/> increased urinary volume     |
| <input type="checkbox"/> throat discomfort   | <input type="checkbox"/> abdominal pain         | <input type="checkbox"/> fainting                     |
| <input type="checkbox"/> cough               | <input type="checkbox"/> nausea/vomiting        | <input type="checkbox"/> numbness, pins and needles   |
| <input type="checkbox"/> sputum              | <input type="checkbox"/> black stools           | <input type="checkbox"/> tremor                       |
| <input type="checkbox"/> bloody sputum       | <input type="checkbox"/> rectal bleeding        | <input type="checkbox"/> muscle weakness or paralysis |
| <input type="checkbox"/> wheezing            | <input type="checkbox"/> vomiting blood         | <input type="checkbox"/> nervousness                  |
| <input type="checkbox"/> chest pain          | <input type="checkbox"/> diarrhea               | <input type="checkbox"/> depression                   |
| <input type="checkbox"/> heart "skipping"    | <input type="checkbox"/> backache               |   |

HAVE YOU HAD COMPLICATIONS WITH PREVIOUS ANESTHETICS? YES ( ) NO ( )

ARE YOU TAKING STEROIDS (CORTISONE)? YES ( ) NO ( )

PRESENT MEDICATIONS:

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

**NEW ENGLAND ORTHOPAEDIC & SPINE SURGERY, LLC**

Peter P. Anas, M.D. Eric P. Carkner, M.D. Howard D. Martin, M.D. Stephen J. Parazin, M.D. Rob Kenney, PA-C

**OFFICE POLICY**

**-Co-payments** are expected at time of service unless other arrangements have been made with this office. Please refer to our patient information brochure for details regarding specific payment policies. Please be advised that we accept CASH, CHECK, MASTERCARD AND VISA

-If your insurer requires a referral, we must verify that at the time of service, a valid referral is on file with your insurer. It is the responsibility of the patient to notify PCP's that they are seeking treatment with our physicians and thus verify that referrals are on file prior to service date. Written verification of a valid referral is required at time of service, otherwise a waiver is signed and patients are responsible for following up on the referral.

**-Prescription requests** are accepted by mail and we ask you put your request for medication in writing along with a self-addressed stamped envelope. Please remember to calculate enough time for your requested prescription to allow for mailing both to and from our office. In most cases, we recommend that you send your request two weeks in advance. In the event of an EMERGENCY, prescription requests will be accepted during regular office hours via telephone.

**-Twenty four hour notice of cancellation** is requested if a patient is unable to keep an appointment. After two successive no-show appointments, further appointments will not be scheduled.

-Children under the age of eighteen must be accompanied by an adult.

**AUTHORIZATION AND CONSENT**

I request that payment under the medical insurance program to be made directly *to New England Orthopaedic & Spine Surgery, LLC*.

I hereby authorize New England Orthopaedic & Spine Surgery, LLC to furnish information to my insurance carrier (s), or its intermediaries in order to process claims.

If services being rendered pertain to a workers compensation injury, I authorize New England Orthopaedic & Spine Surgery, LLC to furnish information to my employer, insurer or its intermediaries in order to process claims.

I also understand that I am financially responsible for charges not covered by this authorization. I permit a copy of this authorization to be used in place of the original.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

## PAIN DRAWING AND SCALE REVIEW

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching  
▲▲▲

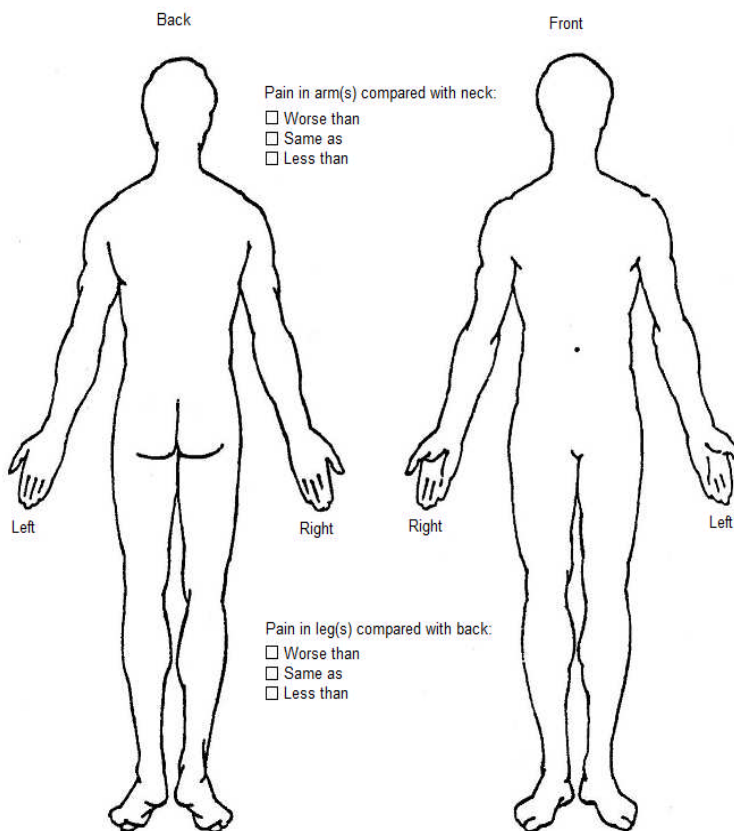
Numbness  
===

Pins and needles  
ooo

Burning  
xxx

Stabbing  
///

Other  
•••



Location of pain or symptoms (indicate on drawing using above symbols):

---



---



---

How bad is the pain on a scale of 1 (best) to 10 (worst)?

1   2   3   4   5   6   7   8   9   10   (circle)

How often is the pain present? \_\_\_\_\_

Is pain referred? \_\_\_\_\_

Sensation \_\_\_\_\_

ACTIVITIES: Is your pain aggravated by any of these?

- \_\_\_\_\_ coughing or sneezing
- \_\_\_\_\_ sitting in a chair
- \_\_\_\_\_ bending forward to brush teeth
- \_\_\_\_\_ when you wake up

- \_\_\_\_\_ in the middle of the night
- \_\_\_\_\_ lying flat on your back
- \_\_\_\_\_ lying flat on your stomach
- \_\_\_\_\_ lying with your knees bent
- \_\_\_\_\_ walking a distance

\_\_\_ PETER P. ANAS, M.D.  
\_\_\_ ERIC P. CARKNER, M.D.  
\_\_\_ HOWARD D. MARTIN, M.D.  
\_\_\_ STEPHEN J. PARAZIN, M.D.  
\_\_\_ ROBERT C KENNEY, PA-c

Account # \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
(Please circle)      Male                  Female  
E-Mail Address: \_\_\_\_\_

PATIENT NAME: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

ADDRESS: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

TELEPHONE: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ RACE: \_\_\_\_\_ RELIGION: \_\_\_\_\_ SINGLE MARRIED WIDOWED DIVORCED

OCCUPATION: \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

PERSON TO NOTIFY IN EMERGENCY (Must be at different address) \_\_\_\_\_  
Name HOME TELEPHONE CELL #

ADDRESS: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ TELEPHONE: ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ TELEPHONE: ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE: ( ) \_\_\_\_\_

INSURANCE INFORMATION (Please check the appropriate box. We will make a copy of your insurance card)

\_\_\_ Blue Cross Blue Shield  
\_\_\_ Medicare  
\_\_\_ Medex  
\_\_\_ Harvard Pilgrim  
\_\_\_ Tufts  
\_\_\_ GIC/State Hancock  
\_\_\_ United Healthcare  
\_\_\_ CIGNA  
\_\_\_ AETNA  
\_\_\_ PHCS  
\_\_\_ FIRST HEALTH/HCV  
\_\_\_ OTHER \_\_\_\_\_

**SUBSCRIBER INFORMATION**  
Subscriber Name \_\_\_\_\_  
Subscriber DOB: \_\_\_\_\_  
Subscriber's Employer \_\_\_\_\_  
Relationship to Patient: (please circle below)  
Self Spouse Child Dependent Other

IS TODAY'S VISIT REGARDING: \_\_\_ MOTOR VEHICLE ACCIDENT \_\_\_ WORKERS COMPENSATION \_\_\_ PERSONAL INJURY

Date of Injury/Accident \_\_\_\_\_ File # \_\_\_\_\_ Contact Person \_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Utilization Review Information: Name \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Address: \_\_\_\_\_

REHAB NURSE/CASE MGR \_\_\_\_\_  
Telephone Cell Phone Fax

Address: \_\_\_\_\_

\*\* COMPLETE THIS SECTION IF AN ATTORNEY IS INVOLVED IN MATTERS PERTAINING TO TODAY'S EXAM\*\*

Attorney Name \_\_\_\_\_ Firm Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

THE GENERAL MEDICAL QUESTIONNAIRE AND THE SPINE TRIAGE FORM HAVE BEEN  
REVIEWED AND AUTHENTICATED BY THE PATIENT AND THE PHYSICIAN AS INDICATED  
BY THE SIGNATURES BELOW.

---

PATIENT NAME (please print)

---

PATIENT SIGNATURE

DATE

---

PHYSICIAN SIGNATURE

DATE



**SPINE TRIAGE FORM (continued)**

HAVE YOU HAD X-RAYS OF YOUR NECK OR LOW BACK? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD A MYELOGRAM? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD A CT SCAN? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD AN MRI? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD AN EMG? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD EPIDURALS, NERVE OR FACET BLOCKS? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD PREVIOUS SPINE SURGERY? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Type/Level, if known \_\_\_\_\_

RESULTS OF PREVIOUS SURGERY: Worse ( ) Same ( ) Improved ( ) Normal ( )

New England Orthopaedic & Spine Surgery, LLC  
830 Boylston Street Suite 211  
Chestnut Hill, MA 02467  
617-734-2450

WELCOME LETTER

Dear Patient:

We are happy to offer an appointment to you!  
As part of our treatment protocol, we must review your responses to the following questions:

Have you previously had a work related injury, auto accident or personal injury that involves the particular area or problem that you are seeking our services today?

YES

NO

*If your answer is "yes", please provide dates and a brief summary of incident/injury and current status. In addition, if you have sought legal advice pertaining to this incident/injury, please list name, address and phone # below.*

Dates                                      Summary                                      Current Status

Attorney                                      Address                                      Telephone

If your answer is "yes", please contact our office as soon as possible and speak with John, our third party coordinator. Even if you have not pursued a claim or reported the injury, it is imperative that you advise our staff of the events surrounding the accident/injury. Please remember that in the event of a third party claim, we are unable to bill your private insurance for services and we must secure authorization from third parties in advance of your appointment, otherwise your appointment may have to be postponed.

We appreciate your understanding.

Peter P. Anas, M.D  
Eric P. Carkner, M.D.  
Howard D. Martin, M.D.  
Stephen J. Parazin, M.D.  
Robert C. Kenney, PA-c

---

Today's Date

Signature