INSIGHT SURGICAL HOSPITAL

Date: _____/ _____/ _____

Insight New Patient Questionnaire

We ask that you fill this form out and return it 1 week prior to your visit otherwise your appointment may need to be rescheduled. This questionnaire is confidential and will be kept as part of your medical record.

Returning patients need only to fill out changed or updated information.

~ Please print clearly ~

☐ Insurance Claim ☐ Worker's Comp Claim ☐ Auto Claim

Personal Information

Patient Name: (First, Middle, Last)	Sex:	Date of Birth:

Email Address:	Social Security Number:
Address: (Street, City, State, Zip)	Home Phone Number:
	Cell Phone Number:
	Work Phone Number:

Referring Physician: (Doctor who sent you here)	Primary Care Physician:
Phone Number:	Phone Number:

Dear Patient: You will be asked questions regarding race and ethnicity during the registration process. We do not ask these questions to limit or deny you services. We ask these questions to give you better care. By gathering this data, we can better prevent, test for, and treat the diseases or health conditions that may affect you. You may refuse to provide us with this information. You will only be asked these questions once.

Race:	Ethnicity:
Asian Black, African or African American American Indian or Alaskan Native White Native Hawaiian or other Pacific Islander Other Races Two or more races Unknown	Hispanic or Latino Neither

Please list all other physicians, lawyers, etc., who should receive a copy of your reports:	
Name:	
Phone:	Fax:
Name:	
Phone:	Fax:
Work Status: (please circle) Employed Unemployed Retired	
Employer:	Occupation:

Emergency Contact		
Name: (First, Last)		
Relation:	Address:	
Home Phone:	Cell Phone:	Work Phone:
Pharmacy Information		
Name:		
Address/Crossroads:	City/State	
Phone Number:	Fax Number:	
Insurance Information		
Primary Insurance:		
Card Holder's Name:	Relationship:	DOB:
Contract #	Group #	
Secondary Insurance:		
Card Holder's Name:	Relationship:	DOB:
Contract #	Group #	
Spouse/Guarantor Information		

Patient's or authorized person's signature: I, the undersigned authorize payment of medical benefits to the doctor for services rendered to me by the physician. I understand I am financially responsible

for all co-pays, deductibles, or services not covered or considered not medically necessary. I authorize release of information concerning health care, advice, treatment, or supplies provided to me, to my insurance carrier. The information will be used only for the purpose of evaluation and administering claims for benefits.

Signature:_____ Date:_____/_____/_____

Medicare patients: Medicare lifetime signature on file: I request that payment of authorized Medicare benefits be made on my behalf to the physician for any services rendered to me by the physician. I authorize any holder of medical information about me to be released to health care financing administration and its agents. I also authorize any information needed to determine these benefits payable for related services released to the health care financing administration or its agents.

Signature:_____ Date:_____/_____/_____

Pain Analysis

What is the primary reason for your visit today? (circle one)

Back Pain / Neck Pain / Leg Pain / Arm Pain / Brain (fill out only what applies to your symptoms)

Is your pain: RIGHT sided LEFT sided BOTH sides

What, if any, is your secondary reason for your visit? (circle all that apply)

Back Pain / Leg Pain / Neck Pain / Arm Pain / Brain / Groin Pain / Shoulder Pain / Foot Pain / Buttocks / Other: _____

Is your pain: RIGHT sided LEFT sided BOTH sides

How long has your primary reason been a problem?

_____

_____

_____

Is the current problem a result of: (circle all that apply)

Approximate date of injury:_____/_____/_____

Work Injury / Auto Accident / Sports Injury / Lifting / Bending / Falling / No apparent cause / Other: _____

Is there any litigation pending? (circle all that apply)

Lawsuit / Auto Claim / Worker's Comp / Disability Claim / Social Security Claim / None
CLAIM #_____

What have you had done for this problem? (circle all that apply)

Treatments: Nothing / Chiropractic Care / Acupuncture / Injections / Physical Therapy / Surgery

Dates of treatments: _____

_____

Names of medications tried: _____

_____

Have you had any of the following?

Imaging: EMG / X-Ray / CT Scan / Myelogram / MRI /Angiogram / Other: _____

_____

Procedures: Shunt Placement / Coiling / Clipping /

Other (s):_____

Have you seen the follow specialties?

Endocrinologist (Name):_____

Ophthalmologist (Name):_____

Do you have any numbness? **YES or NO**

Where: _____

How frequent? Constant / Intermittent

Do you have any weakness? **YES or NO**

Where: _____

How frequent? Constant / Intermittent

Do you have any trouble controlling your bladder? **YES or NO**

Do you have any trouble controlling your bowels? **YES or NO**

What makes the pain worse? (circle all that apply)

During Exercise / After Exercise / Sitting / Standing / Walking / Bending / Pushing / Pulling / Squatting / Lying down / Coughing / Other: _____

What reduces your pain? (circle all that apply)

Lying down / Sitting / Standing / Walking / Medication / Shifting or Changing positions / Manipulation / Nothing / Other: _____

Do you use a cane, walker or wheel chair to help you get around? _____

Have your symptoms caused you to: (circle all that apply)

Limit / Stop / No Change Working (if previously working)

Limit / Stop / No Change Housework & Yardwork

Limit / Stop / No Change Daily Activities

Please check all that apply and indicate how long these symptoms have been occurring:

☐Seizures _____

☐Headaches _____

☐Blackouts _____

☐Dizziness_____

☐Paralysis or weakness of limb(s) _____

☐Nervousness _____

☐Difficulty in going to sleep _____

☐Loss of sensation _____

☐Loss of balance _____

☐Loss of coordination _____

☐Double vision _____

☐Difficulty in speaking _____

☐Depression _____

☐Early morning awakening _____

☐Difficulty with memory for past events _____

☐Difficulty with memory for recent events _____

☐Difficulty with thinking or problem solving _____

☐Excessive Nasal Drainage _____

Please list any/all other symptoms that you are having:

_____

_____

_____

Current Medications (*Put any additional medications on another sheet*)

Name	Strength (mg or ml)	How Often (per day)	Start Date

Do you feel you've become addicted to any of these medications?
YES or NO Please indicate which medications with a *

ALLERGIES: None Known / Sulfa / Penicillin / Latex / Other (s): _____

_____

Are you on any blood thinners? YES or NO
Name:_____ Why?_____

Do you have any metal in your body? YES or NO
Where? _____

Surgical History

Date	Surgery	Name of Surgeon	Complications

Do you have, or did you have, any of the following: (circle all that apply)

Medical History

High Blood Pressure: ___Essential Primary Hypertension (I10)

Blood Clots/Embolism: ___Personal History of other venous thrombosis and embolism (Z86.718)

Diabetes: ____ Type 2 diabetes with diabetic neuropathy (E11.40)
____ Type 2 diabetes with unspecified complications (E11.8)
____ Type 2 diabetes unspecified (E11.9)

COPD: ____ Chronic obstructive pulmonary disease (J44.9)

High Cholesterol: ___Pure Hypercholesterolemia, Unspecified (e78.00)

Chronic Bronchitis: ____ Simple chronic bronchitis (J41.0)

Asthma: _____Unspecified asthma (J45.909)

Arthritis: ___Unsepcified Osteoarthritis (M19.90)

Osteoporosis: ____Age-related osteoporosis without current pathological fracture (M81.0)

Pacemaker: ___Prescence of cardiac pacemaker (Z95.0)

Heart Attack: ___Old Myocardial Infarction (I25.2)

TIA (Mini Stroke): ___Transient Cerebral Ischemic Attack, Unspecified

Ulcers: ___Personal History of Diseases of the skin and subcutaneous tissue (Z87.2)

Emphysema:____ Other emphysema (J43.8)

Rheumatoid Arthritis: ____ Rheumatoid arthritis with rheumatoid factor (M05.9)
____ Rheumatoid myopathy with rheumatoid arthritis of unspecified site (M05.40)

Hepatitis C: ____ Chronic viral hepatitis C (B18.2)

Cirrhosis of the liver: ____ Alcoholic cirrhosis of liver without ascites(K70.30)
____ with ascites (K70.31) ____ Other chirrhosis of liver (K74.89)

Renal/Kidney disease: ____ End stage renal disease (N18.6)
____ Chronic kidney disease stage 1 (N18.1) ____ Chronic kidney disease stage 2 (N18.2)
____ Chronic kidney disease stage 3 (N18.3) ____ Chronic kidney disease stage 4 (N18.4)
____ Chronic kidney disease stage 5 (N18.5)

Alzheimers/Dementia: ____ Alzheimer's disease with early onset (G30.0)
____ Alzheimer's disease with late onset (G30.1) ____ Alzheimer's unspecified (G30.9)
____ Unspecified dementia without behavioral disturbance (F03.90)
____ Unspecified dementia with behavior disturbance (F03.91)

Depression/Bipolar Disorder: ____ Major depressive disorder, recurrent, moderate (F33.1)
____ Bipolar II disorder (F31.81) ____ Other bipolar disorder (F31.89)

Schizophrenia: ____ Paranoid schizophrenia unspecified (F20.0)
____ Unspecified schizophrenia (F20.3)

Multiple Sclerosis: ____ Multiple sclerosis (G35)

Epilepsy/Seizures : ____Other epilepsy not intractable (G40.802) ____ Seizures (G40.89)

Heart Failure/Atrial Fibrillation/Unstable Angina: ____ Heart failure unspecified (I50.9) ____ Unspecified atrial fibrillation and atrial flutter (I48.9) ____ Unstable angina (I20.0)

Stroke: ____ Other cerebral infarction (I63.8) ____ Cerebral infarction unspecified (I63.9)

Cancer: ____ What type? _____

Others: _____

None: _____

Hospitalizations		
Date	**Hospital Name**	**Reason**

Family History (Please circle all that applies)		If deceased please explain the cause
Is your Father:	Alive or Deceased	
Is your Mother:	Alive or Deceased	
Is your Paternal Grandfather:	Alive or Deceased	
Is your Paternal Grandmother:	Alive or Deceased	
Is your Maternal Grandfather:	Alive or Deceased	
Is your Maternal: Grandmother:	Alive or Deceased	

Social History

Marital Status: _____

Work Status: Employed_____ Unemployed_____ Retired_____

Occupation: _____

Are you currently able to work? YES or NO

If no, is it due to this problem? YES or NO When did you last work? _____

Was your current condition caused by a…?

Work related injury: _____ Date: _____ Is this a workman's compensation case? YES or NO

Motor vehicle accident: _____ Date: _____ Is this a Personal Injury case? YES or NO

Are you on disability? YES or NO In the process of obtaining Disability? YES or NO

Do you travel? Locally Statewide Nationally Internationally:_____

Caffeine intake per day: _____

Do you presently use tobacco or smoke? **YES or NO** Cigarettes__ Cigar__ Chew__

If yes, indicate amount or number of packs/day: _____

Have you ever previously smoked? YES or NO How many years? _____ Amount: _____

When did you quit? _____

Do you drink alcohol? **YES or NO**

Type:_____ Amount:_____ Frequency:_____

Do you use recreational drugs? **YES or NO** What type & amount**:** _____

How did you hear about us?

_____

_____

_____

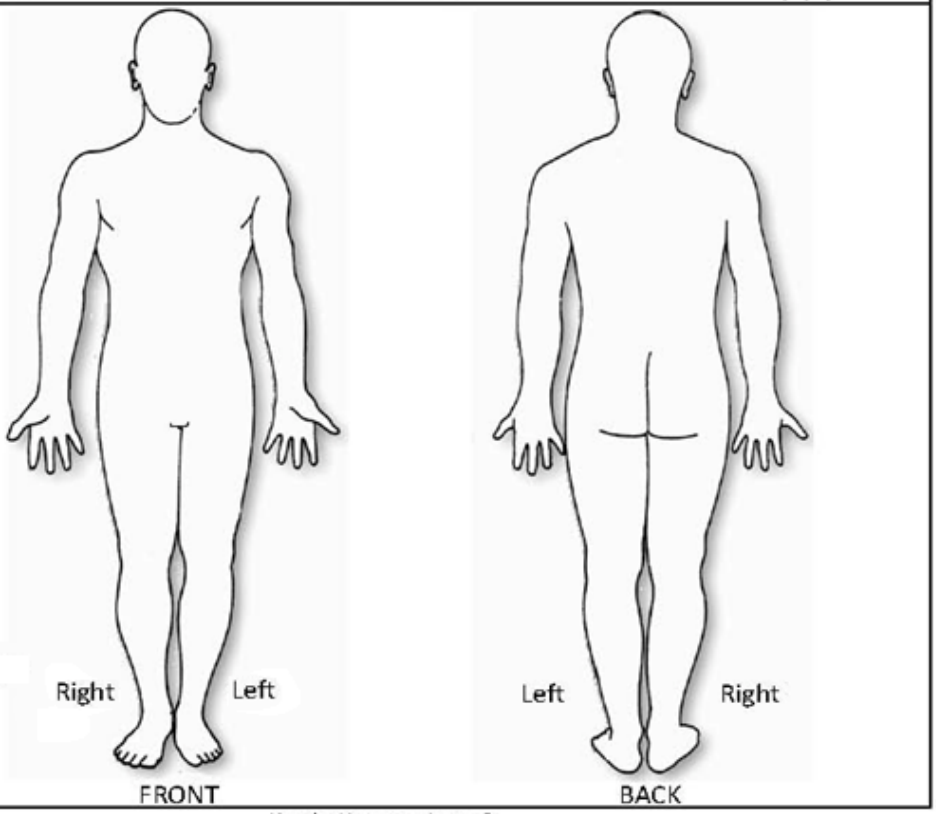
PATIENT PAIN DRAWING

Name _____ Date _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching	Numbness	Pins & Needles	Burning	Stabbing
^^^	= = =	O O O	xxx	/ / /



How bad is your pain now?

1) Mark an X on the body form where the pain is worse now.

2) Mark on the line how bad your pain is now. (Circle a number)

MILD PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

(1 being mild pain, 10 being worst possible pain)

How bad is your pain, on average, on a scale of 1-10? _____

If you have pain in other areas, how bad, on average, on a scale of 1-10? _____