Peter J. Curcione, DO
Athletic Orthopedic and Reconstructive Center

For office use only:

Acct#: _____

PATIENT INFORMATION					
Last Name:		**First Name:**			**Middle Initial:**
*Date of Birth:	Age:	*Sex: (please circle) **Male or Female**	Social Security #		
Mailing Address:		City:		State:	Zip Code
***Race:**		***Ethnicity:**	***Preferred Language:**		
E-Mail Address:			**Marital Status:** (Please circle) MARRIED, SINGLE, DIVORCED, WIDOWED, OTHER _____		
Home Phone:	Cell Phone:		Driver's License #		State:
Employer:		Occupation/Title:	Work Phone w/ Extension:		
Street Address: *(if different from mailing)*		City:		State:	Zip Code
Northern Address:		City:		State:	Zip Code:
Spouse's Name:	Spouse's Cell phone:		Spouse's Work Phone:		

IN CASE OF EMERGENCY			
Name of Emergency Contact:	Relationship:	Home Phone:	Work or Cell#

PHARMACY INFORMATION	
Pharmacy Name:	Telephone/Location:

PHYSICIAN INFORMATION			
Primary Care Physician Name:	Phone #	Which office location:	Did They Refer you?
Cardiologist Physician's Name:	Phone #:	Which office location:	Last EKG?
Pain Management Physician:	Phone #	Which office location:	

***Items Required for Electronic Medical Records Meaningful Use Guidelines Required by the US Government.**

INSURANCE INFORMATION *(PLEASE PRESENT YOUR CARD AND DRIVERS LICENSE FOR SCANNING)*

Is it okay to leave a detailed message on voicemail/answering machine? _____
Beside yourself, who is it okay to leave a detailed message with? _____

I hereby authorize treatment by Kagan, Jugan & Associates, P.A. (Peter J. Curcione, DO) as deemed reasonable and necessary by the physician at the time of my visit.

X _____ **X** _____
SIGNATURE DATE

I, _____, hereby assign all medical and/or surgical benefits to which I am entitled to Kagan, Jugan & Associates, P.A. Peter J. Curcione, DO) A copy or fax of this assignment is valid as the original.

X _____ **X** _____
SIGNATURE DATE

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PLEASE PRINT CLEARLY

Name: _____ Date: _____

Chief Complaint: Why are you seeing the doctor today? *(Please include body part and which side):*

_____

_____

How & when did the injury/symptoms start? _____

Is this injury due to an accident? Yes or No _____ What type? motor vehicle, work-related, fall etc (please describe): _____

_____

Have you been treated anywhere else for this injury/body part in the past? Yes or No (other physician, ER, walk-in, Chiropractic, etc)

If yes, where? _____ What treatment did they give you? (Splint, meds, injections)_____

Were X-rays, MRI, CT, EMG/NCV or other studies done? _____

Did you bring these films or reports? _____ Have you missed any work for this injury?_____

SOCIAL HISTORY

Height: _____ Weight: _____ Right / Left OR Ambidextrous Handed? _____

Do you smoke or use tobacco? _____ If yes, Cigarettes, Pipe, Cigars or Oral e.g.: chew or dip? How many/ much per day?_____

Have you ever used tobacco products? _____How long ago did you quit? _____

Do you drink alcohol? _____ If yes, how much do you drink weekly? _____

Who do you live with? Spouse, Self, Family, Friends or Other (explain) _____

What is your work status? (Please Circle)Full-time/Part-time/Student/Housewife/Retired/Medically Disabled

What is your occupation? _____

If you are medically disabled, was it due to this injury or something else?

Please describe_____

ARE YOU UNDER THE CARE OR TREATING WITH A PAIN MANAGEMENT PHYSICIAN? YES OR NO
IF YES: Physician name: _____ ___ Phone: _____

CURRENT MEDICATION: (*PLEASE LIST **ALL PRESCRIPTION** AND OVER THE COUNTER MEDS INCLUDING VITAMINS AND HERBAL SUPPLEMENTS)*

_____

_____

_____

ALLERGIES to MEDICATION: (*PLEASE LIST ALL AND THE REACTION)*

_____

_____

Do you have a metal allergy? Yes or No explain: _____
Do you have any food allergies? Yes or No explain: _____
Do you have a LATEX allergy? Yes or No explain: _____
Do you have an allergy to eggs? Yes or No explain: _____

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PERSONAL PAST SURGICAL HISTORY

Please specify right or left and approximate dates

GENERAL SURGERY	Abdominal aortic aneurysm (AAA), Appendix, Urinary bladder lift, Gall bladder, Hemorrhoidectomy, Bowel resection, Colonoscopy, Esophageal dilation, Colostomy, Illiostomy, Polyp removal From where: (Colon, esophagus etc)_____ Hernia repair what Type: (inguinal, hiatal etc.) (Right or left)_____						
ORTHOPEDIC SURGERY	**BODY PART**	**PROCEDURE & WHICH SIDE (IF IT APPLIES)**				**DATE:**	**SURGEON**
	SHOULDER	RT		LT			
	ARM/ELBOW	RT		LT			
	WRIST	RT		LT			
	HAND	RT		LT			
	HIP	RT		LT			
	KNEE	RT		LT			
	ANKLE	RT		LT			
	FOOT	RT		LT			
	OTHER:	RT		LT			
PLASTIC SURGERY OB/GYN SURGERY OTHER SURGERY	FACE LIFT/EYELIDS						
	EYES (CATARACTS) LASIX ETC.						
	BREAST REDUCTION/AUGMENTATION						
	BREAST BIOPSY (NEEDLE/STEREO)						
	C-SECTION						
	HYSTERECTOMY						
	PROSTATECTOMY						
HEART SURGERY	PACEMAKER						
	BYPASS						
	VALVE REPLACEMENT						
	STENT(S)						
	OTHER:						
E N T SURGERY	TONSILLECTOMY						
	ADENOIDS						
	THYROID						
	EARS (TUBES ETC)						
	SINUS						
	OTHER:						
VASCULAR SURGERY	CAROTID						
	STENTS						
	VEIN STRIPPING						
	OTHER:						
SPINE/NEURO/ BRAIN SURGERY	CERVICAL	LEVEL:					
	THORACIC/DORSAL	LEVEL:					
	LUMBAR:	LEVEL:					
	BRAIN						
OTHER SURGERIES NOT LISTED	Other: _____ _____ Hospitalizations for major Illness:_____ _____						

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Medical History (PLEASE CIRCLE ALL THAT APPLY)

GENERAL	NONE Anemia, Alcoholism, Allergies, Anxiety, Bipolar disorder, Bleeding disorder, Blood transfusion, Cataracts , Chicken pox, Deafness, Depression, Drug abuse, Eczema/psoriasis , Glaucoma, Hay fever, HIV/AIDS ,Macular Degeneration Mumps/Measles, Leukemia, Lymphoma, Legally blind, Neurofibromatosis , Rashes/Hives, Rubella, Suicide attempt, Tinnitus(ringing in ear), Torn retina, Vertigo, Other:_____
BRAIN NEURO	NONE Stroke, TIA, Seizures, Alzheimer's, Memory difficulty, Headaches, Migraines, Aneurysm, Benign tumors, Tremors, Parkinson's Dizziness, Brain , Other:_____ Tingling *Where?*_____
CARDIO/ VASCULAR	NONE High blood pressure/ HTN, Heart attack , Chest pain, Phlebitis, Aneurysm , Blood clot/DVT, Excessive bleeding, Easily bruise, Peripheral vascular disease, Angina , Irregular heartbeat, Atrial fibrillation, Aortic valve disease, Mitral valve prolapsed, Abdominal aortic aneurysm, Palpitations Other:_____
GI/LIVER	NONE Ulcer, GERD/reflux ,IBS , Crohn's disease, Colitis, Hepatitis A, B or C, Pancreatitis, Diverticulitis, Cirrhosis, Gall bladder Appendix, Polyps, Hemorrhoids, Abdominal pain, Nausea, Vomiting, Indigestion, Heartburn, Diarrhea Other:_____
MUSCULAR/ SKELETAL	NONE Arthritis, Rheumatoid arthritis, Osteoarthritis, Fibromyalgia, Gout, Scoliosis, Osteoporosis, Osteopenia, Bone pain Sprains/Fractures/Tendonitis/ Muscle Pain/ Joint Pain Please specify what body part:_____ Other: _____
RESPIRATORY LUNG	NONE Asthma, Bronchitis, COPD, Emphysema, Pneumonia, Pulmonary embolus (PE), SOB , Wheezing, Cough, Sleep Apnea Other:_____
URINARY/ RENAL	NONE Kidney failure(dialysis), Transplant, Stones, UTI/urinary tract infection, Urinate frequently, Burning with urination, Difficulty with urination, Enlarged prostate, Erectile dysfunction, Sexually transmitted disease, Infertility Other:_____
ENDOCRINE	NONE Thyroid: *High or low,* Excessive thirst Diabetes type 1 or 2: *Diet controlled* *Medication controlled* *Insulin dependent* Pituitary disorder Other:_____
CANCERS	NONE Breast: Lumpectomy (Right or Left) Mastectomy (Right or Left) Cervical ,Ovarian , Uterine , Lung, Prostate, Colon, Stomach , Colon, Liver, Pancreatic, Throat/ Esophagus Skin cancer (type):_____, Bone cancer where? _____ Other: _____

FAMILY HISTORY (PLEASE MARK ALL THAT APPLY)

	MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS	OTHER: (SPECIFY)
CANCER						
DIABETES						
EPILEPSY						
HEART PROBLEMS						
HYPERTENSION/ BLOOD PRESSURE						
STROKE						
OSTEOPOROSIS						

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