SCHEINBERG ORTHOPEDIC GROUP

Richard D. Scheinberg, M.D.
Medical Director

Mark Jamali-Ashtiani P.A.-C
Director of Physician Assistants

Welcome to our clinic! Prior to being seen, we ask you to fill out these forms as accurately as possible. While some of the questions may not seem relevant to your problem, they give us an idea about your medical status, the circumstances relating to your problem and your overall situation. Please sign and date the bottom of the last page. Thank you.

Last Name _____ First Name _____ DOB _____

Address _____ City _____ Zip _____

Home Phone # _____ Work Phone # _____ Soc. Sec # _____ Email Address _____

Male _____ Female _____ Weight _____lbs. Height _____

MARITAL Status: Single__ Married__ If married, please provide spouses name: _____

Language: _____ Spanish _____English Other (Specify) _____

Do you have an interpreter? __Yes __No Name: _____Phone #:_____

Race/Ethnic Group: ____ African-American ____Hispanic ____European ____Asian ____American

____ American-Indian ____Hawaiian other _____

Were you referred to our office by another physician or by an attorney: _____Yes _____No

If so, what is the Physician's or Attorney name and contact information:

Name_____ Address _____

_____Phone #: _____

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History of Present Illness

Is this a work related injury? _____Yes _____No

Date of Injury: _____ Claim #: _____

Name of the Insurance: _____ Phone # _____

Address: _____

Name of the Employer at time of accident: _____

Address: _____

Phone: _____ Job: _____

Description of the job: _____

_____

_____

_____

Briefly describe how injury occurred: _____

_____

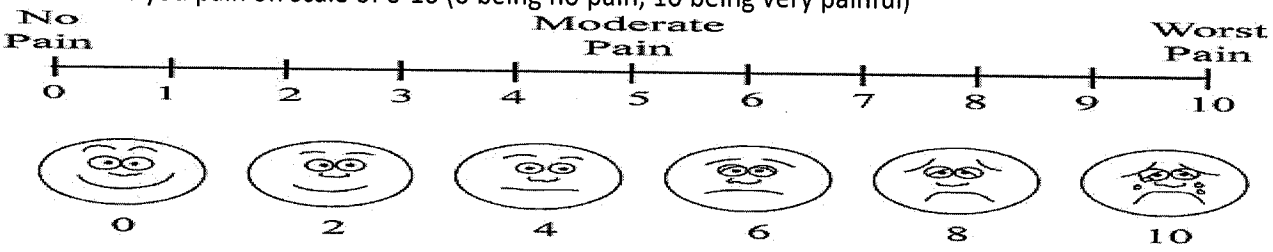
_____

_____

_____

_____

Please rate you pain on scale of 0-10 (0 being no pain, 10 being very painful)



How would you describe your pain? (Burning, aching, throbbing, tingling etc.) _____

_____

_____

Have you had any previous treatment for this problem? If so, what has been done so far? _____

_____

_____

List all major illnesses (Diabetes, high blood pressure, heart attack, etc.) or Surgeries:

_____

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401 Chapala Street, Suite 102
Santa Barbara, CA 93101
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Fax (805) 682-6394

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530 E. Main Street
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List any Medications you currently take, doses, and how often (Rx and over the counter): _____

Have you had problems with anesthesia before: YES NO if YES, what problem? _____

FAMILY HISTORY (MOTHER, FATHER, GRANDPARENT, SIBILING)

Has any member of your family had these diseases? (Circle) _____**YES** _____**NO** _____**UNKNOWN**

DIABETES_____, HYPERTENSION_____, HEART DISEASE_____,

STROKE_____, CANCER_____, THYROID DISEASE_____,

ARTHRITIS_____ OTHER FAMILY DISEASES_____

SOCIAL HISTORY

Do you drink alcoholic beverages? _____**YES** _____**NO** IF YES, HOW MUCH? _____

Do you use any form of tobacco? ___**YES** ___**NO** IF cigarettes, How many per-day? _____

Are you Involve in any sports? ___**Yes** ___**No** if so, list all. _____

Do you use recreational drugs? ___**Yes** ___**No** please specify: _____

Do you have allergies to any medications? _____ **NO** _____**YES** please List_____

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Do you currently have any problems in the following areas? If YES, please provide additional information.

	Yes	No	Details/ Dates
GENERAL /Constitutional. Fever, heat stroke, weight loss, weight gain, usually tired			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth etc.)			
RESPIRATORY Congestion, wheezing, short of breath, etc.			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
GASTROINTESTINAL stomach upset, diarrhea, constipation, hernia, ulcer, etc.			
GENITAL, KIDNEY, BLADDER painful or frequent urination, impotence, yellow jaundice,			
FEMALES are you pregnant? Nursing?			
ENDOCRINE diabetes, hypothyroid, etc.			
NEUROLOGICAL numbness, headache, seizures, paralysis, etc.			
PSYCHIATRIC anxiety, depression, insomnia, etc.			
SKIN pimples, warts, growths, rash, etc.			
MUSCLE, BONES JOINTS join pain, stiffness, swelling, cramps, arthritis, etc.			
BLOOD/LIMPH bleeding, high cholesterol, anemia, problems related to blood transfusion, etc.			
ALLERGIC/ IMMUNOLOGIC sneezing, swelling, redness, itching, hives, lupus, etc.			

I authorize release of any records and billing to my attorney or insurance company. I authorize payments from my insurance company to be paid directly to Richard Sheinberg M.D. I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient Signature *Date*

APPOITMENT DATE: _____ **TIME:** _____

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