David John, MD
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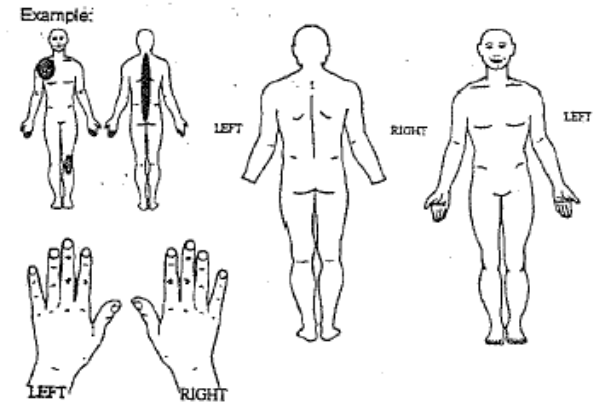
Birthplace_____

Name_____ Birthdate_____/_____/_____
Last First MI Maiden Month Day Year
Address_____ Age_____ Sex: ☐F ☐M SSN:_____
_____ Home phone_____ Cell phone_____
Marital Status: ☐ Never Married ☐ Married ☐ Divorced Work phone_____Other_____
☐Separated ☐ Widowed Spouse/Significant Other: ☐Alive/Age_____ ☐Deceased/Age_____

Education: Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School_____
Occupation_____Number of hours worked/ average per week_____

Name of person making referral:_____
Name of Primary Care Physician:_____
Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name:_____
Describe your present symptoms briefly:_____
_____
_____
_____
_____
_____
_____
Date symptoms began (approximate):_____
Diagnosis:_____
Previous treatment for this problem (include physical therapy, surgery and injections, medications.):
_____
_____
_____
_____

Please shade all the locations of your pain over the past week on the body figures and hands.



Rheumatologic (arthritis) History

At any time have you or a blood relative had any of the following? (check if "yes")

Self		Relative (Relationship)	Self		Relative (Relationship)
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	

Other arthritis conditions:_____

Social History

Do you drink caffeinated beverages? ☐Yes ☐ No
Cups/ glasses per day?_____
Do you smoke? ☐ Yes ☐ No ☐ Past–How long ago?_____
Do you drink alcohol? ☐ Yes ☐ No Number per week?_____
Has anyone ever told you to cut down on your drinking?
☐ Yes ☐ No
Do you use drugs for reasons that are not Medical? ☐ Yes ☐ No
If yes, please list_____
_____
Do you exercise regularly? ☐ Yes ☐ No

Type_____
Amount per week?_____
How many hours of sleep do you get per night?_____
Do you get enough sleep at night? ☐ Yes ☐ No
Do you wake up feeling rested? ☐ Yes ☐ No

Past Medical History

Do you now or have ever had: (check if "yes")

☐ Cancer	☐ Heart Problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach Ulcers	☐ Anemia
☐ Rheumatic Fever	☐ Bad Headaches	☐ Colitis
☐ High blood pressure	☐ Kidney disease	☐ Psoriasis
☐ Tuberculosis	☐ Emphysema	☐ HIV/AIDS
☐ Jaundice	☐ Pneumonia	☐ Glaucoma
☐ High cholesterol		

Other significant illness (please list)_____
_____
Natural or Alternative Therapies (chiropractic, magnets, massage, over -the-counter preparations, etc.)
_____
_____

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ Yes ☐ No Describe:_____
Any other serious injuries? ☐ Yes ☐ No Describe:_____

Family History

	If Living		If Deceased	
	Age	Health	Age of Death	Cause
Father				
Mother				

Number of siblings_____ Number living_____ Number deceased_____
Number of children_____ Number living_____ Number deceased_____ List age of each_____
Health of children_____
_____

Do you know of any blood relatives who has or had (check and give relationship):
☐ Cancer_____ ☐ Heart Disease_____ ☐ Rheumatic fever_____ ☐Goiter_____
☐ Tuberculosis_____ ☐ Leukemia_____ ☐ High blood pressure_____ ☐ Stroke_____
☐ Alcoholism_____ ☐ Epilepsy_____ ☐ Bleeding tendency_____ ☐ Colitis_____
☐ Psoriasis_____ ☐ Asthma_____

Medications

Drug allergies: ☐ No ☐ Yes To what?_____
_____
Type of Reaction:_____

Present medications (List any medications you are taking, including all over-the-counter medications also.)

Name of Drug	Dose (Include strength & pills taken per day)	How long has medication been taken?	Please check: Helped? A lot	Some	Not at All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

Patient's Name_____ Date_____ Physician Initials_____

Employer Information

Employer Name_____
Address_____

Insurance Information

***** Primary Insurance_____ Subscriber Name_____
Member Number_____ Subscriber Date of Birth_____
Subscriber SSN_____ Relationship_____

*****Secondary Insurance_____ Subscriber Name_____
Member Number_____ Subscriber Date of Birth_____
Subscriber SSN_____ Relationship_____

Emergency Contacts

Name_____ Phone Number_____
Address_____
Relationship_____

Name_____ Phone Number_____
Address_____
Relationship_____

The following information is presented for informational purposes and as formal notification:

1.The practices of David John, M.D. and Deryll U. Ambrocio, M.D. do not participate with Workmen's Compensation or No-Fault and that you attest that the issues at hand are not related to such events.
2. That, by tradition, a copy of medical records will be forwarded at no charge to a requesting doctor's office. All other records requested are subject to copying charges.
3. As of January 1, 2010, charge will occur for certain forms and for preparation of letters to outside entities. The volume of such requests has dramatically increased. Examples are jury duty letters, travel-related letters, FMLA forms and insurance company appeal letters. The charge will be $10.00 unless otherwise stated in advance.
4. Finally, we reserve the right to impose a $25.00 fee for "no-show" or late cancellation of appointments. Please call to cancel/reschedule at least 24 hours prior to your scheduled appointment.

Patient's Signature_____ Date_____