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Name: _____ Date of Birth: _____/_____/_____
Last First MI Month Day Year

Address: _____ Sex: ☐ Male ☐ Female
City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Birthplace: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____
Occupation: _____

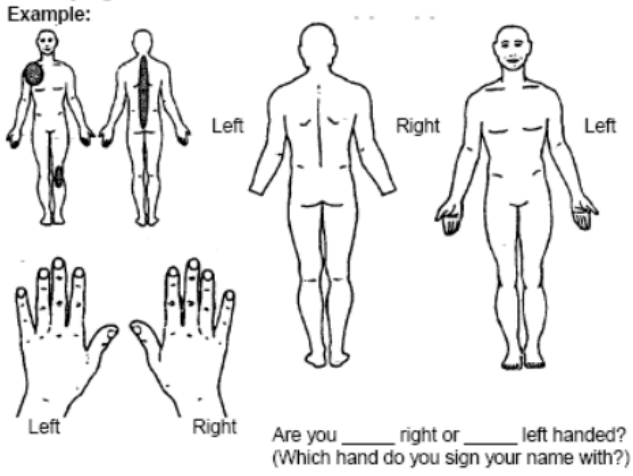
Name of person making referral: _____
Name of Primary Care Physician: _____
Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name:_____

Describe your present symptoms: _____
_____
Date symptoms began: _____
Previous treatment for this problem (include physical therapy, surgery, injections, medication):_____
_____

Rheumatologic History: Have you or any blood relative had any of the following? (if yes, check)

Self	Relative (Relationship)	
		Osteoarthritis
		Gout
		Childhood arthritis
		Lupus or "SLE"
		Rheumatoid arthritis
		Ankylosing Spondylitis
		Osteoporosis
		Other, _____

Please shade all the locations of your pain over the past week on the figures below.



Past Medical History: Do you have or have you ever had

☐ Cancer ☐ High Cholesterol ☐ Pneumonia
☐ Goiter ☐ Heart problems ☐ Asthma
☐ Cataracts ☐ Diabetes ☐ Stroke
☐ Rheumatic Fever ☐ Stomach Ulcers ☐ Epilepsy
☐ High Blood pressure ☐ Migraines ☐ Anemia
☐ Tuberculosis ☐ Kidney disease ☐ Colitis
☐ Jaundice ☐ Emphysema ☐ Psoriasis
☐ HIV/AIDS ☐ Glaucoma
☐ Other: _____

Social History:

Do you drink caffeinated beverages? ☐ Yes ☐ No

If yes, how many cups per day? _____

Do you smoke tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks per week? _____

Do you vape? ☐ Yes ☐ No

Do you use cannabis? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

If yes, type and amount a week: _____

_____

How many hours of sleep do you get a night? _____

Do you get enough sleep? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

Previous Operations/Surgeries:

Type of Operation	Year	Reason for Operation
1.		
2.		
3.		
4.		
5.		

Any previous fractures? ☐ Yes ☐ No If yes, describe _____

Family History:

	Age	Health	If deceased, cause of death
Father			
Mother			

Number of siblings: _____ Number living: _____ Number deceased: _____

Number of children: _____ Number living: _____ Number deceased: _____

Drug Allergies:

☐ Yes (please list below) ☐ No

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Medications: List any medications you are taking, including all over-the-counter medications.

Name of Medication	Dose/Strength	Directions	How long have you been taking the medication?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Employer Information:

Employer Name: _____
Employer Address: _____

Insurance Information:

Primary Insurance:	Subscriber Number:
Subscriber Name:	Subscriber Date of Birth:
	Relationship to Patient:
Secondary Insurance:	Subscriber Number:
Subscriber Name:	Subscriber Date of Birth:
	Relationship to Patient:

Emergency Contacts:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

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

1. The practice of Deryll U. Ambrocio, M.D. does 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. Charges will occur for certain forms and for preparation of letters to outside entities. The volume of such requests has dramatically increased. Examples: jury duty letters, travel-related letters, FMLA forms and insurance company appeal letters. The charge will be $20.00 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: _____