SECKLER ORTHOPEDICS & SPORTS MEDICINE
2444 HIGHWAY 34-SUITE B, MANASQUAN NJ 08736
732-528-4407

WORK RELATED CONDITION/ACCIDENT/INJURY/ INCIDENT

ALL PAGES MUST BE COMPLETED ENTIRELY

FULL NAME: _____ BIRTHDATE: _____

ADDRESS:_____ PHONE: _____

Preferred Name: _____□ MALE □ FEMALE □ Single □ Married □Widowed □ Separated /Divorced

E-Mail address (to access your Medical records)_____

EMERGENCY CONTACT NAME & PHONE:_____

EMPLOYER NAME, LOCATION, TELEPHONE _____

OCCUPATION: _____ SOCIAL SECURITY # _____

JOB DUTIES: _____

Date of Accident: _____ Location of Accident: _____

***Did you report your injury/condition to your employer? [ ] Yes IF [ ] No, I have not reported this to my employer or compensation carrier, complete and sign this page only, and ask to speak with the office manager.**

WC INSURANCE CO Name, Address, Phone:_____

Adjuster/Case Manager Name_____ Phone _____

Claim #_____ Have you lost time from work? [ ]No [ ]Yes, from_____ to_____

What symptoms do you have today? _____

Describe where you were and what you were doing at the time of the injury/accident: _____
_____
_____

Did you go to the Hospital? [ ]No [ ]Yes, Date:_____ Name of Hospital:_____
[ ] X-rays _____ [ ]MRI_____ Other treatment:_____

Any person who knowingly or with intent to defraud any insurance company or other persons, provides false or misleading information concerning any fact(s), therefore commits an act of insurance fraud, which is a crime, subject to criminal prosecution and or civil penalties. Subject to the requirements of applicable law, we may release Protected Health Information about you for programs that provide for work-related injuries or illnesses. By signing this form, I understand I shall be liable for any charges not covered by my insurance as a result. NJ law requires all employers to provide work comp insurance. Work injuries are not compensable under private or commercial health insurance plans.

➡ GUARANTOR SIGNATURE_____ DATE_____

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PATIENT NAME: _____ BIRTHDATE: _____

NAME & LOCATION OF FAMILY DOCTOR_____

PHARMACY NAME, STREET/TOWN, PHONE _____

WHO/HOW WERE YOU REFERRED TO OUR OFFICE _____

REASON FOR YOUR APPOINTMENT TODAY □ Work Comp Evaluation □ Second Opinion □ Legal □ Disability

Describe the part of your body affected: □KNEE □SHOULDER □OTHER _____ □ RIGHT □ LEFT □ Both

Date you first noticed any symptom(s) _____ List all symptoms _____

List any other Physician(s) you saw for this problem _____

Check all services/treatments that you have had for this particular problem:
□ Consultation □ Physical therapy □ Injection □ Surgery __NO __YES, when_____ DR _____

□ Other treatment_____

List any medications you are or have taken for this problem

Name of Medication	Dosage	Frequency	Last Dose Date

On a scale between 0 (None) and 10 (Worst), how severe is your pain _____

0 1 2 3 4 5 6 7 8 9 10

What relieves your pain/discomfort _____

What aggravates your pain/discomfort _____

Have you contacted any attorney □NO □YES, Name and Address _____

<u>The Doctor will not complete disability forms during your visit</u>. If you do not provide your occupation including job duties, your form will NOT be completed/signed by the Doctor. All Forms will be completed and mailed 7-10 working days from the date of your surgery, or from the date which the Doctor renders you disabled. There may be a fee for completing forms. Medication requests and or prescription refills will be taken Monday through Friday *<u>during office hours only</u>*. There is a $50 fee if you NO SHOW, or fail to provide 1 day advanced notice.

➡ **Signature_____ Date_____**

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PATIENT NAME: _____ BIRTHDATE: _____

Patient Medical History

Please check if you have had any of the following:

□ Alcoholism	□ CVA	□ Liver Disease
□ Anemia	□ Dementia / Alzheimer's	□ Migraine
□ Anxiety	□ Disc Disease	□ Multiple Sclerosis
□ Arrhythmia	□ DJD	□ Nephrolithiasis
□ Arthritis	□ Depression	□ Obesity
□ Asthma	□ DM Type I	□ Osteoarthritis
□ Atrial Fibrillation	□ DM Type II	□ Osteoporosis
□ Bronchitis	□ Emphysema	□ Prior MI
□ CAD	□ Epilepsy	□ Pulmonary Disease
□Cancer Type:_____	□ Fracture	□ Rheumatoid Arthritis
□ Cardiovascular Disease	□ GERD	□ Seizures
□ CHF	□ Glaucoma	□ Sickle Cell Disease
□ Crohn's Disease	□ Hepatitis	□ STD
□ Cirrhosis	□ High Cholesterol	□ Thyroid Disease
□ Colitis	□ Hyperlipidemia	□ TIA
□ Constipation	□ Hypertension	□ Tuberculosis
□ COPD	□ Implanted Medical Devices	□ Ulcers
□ CRF	□ Kidney Disease	□ Valve Problems

□Other_____ □ Allergies _____Reaction_____

Is there any chance you may be pregnant? □ Yes □ No Last date of menses: _____

Past Surgical History Or initial if _____□ No prior surgical history

Please check if you have had any of the following:

□ Shoulder Surgery	Date_____	□ Appendectomy	Date_____
□ Spinal Surgery	Date_____	□ D & C	Date_____
□ Knee Surgery	Date_____	□ Hysterectomy	Date _____
□ Total Knee Replacement	Date_____	□Tonsillectomy	Date_____
□ Total Hip Replacement	Date_____	□ Tubal Ligation	Date_____
□ Other _____	Date_____	□ Mastectomy	Date_____

□ **ANY/ALL Surgical Complications: □ NO □ YES, describe**_____ **Date**_____

□ **ANY/ALL Infections: □ NO □ YES, describe:**_____ **Date**_____

□ **DVT (BLOOD CLOT) □ NO □YES Date** _____

Any problems with anesthesia? □ NO □ YES,describe:_____

PLEASE DESCRIBE ALL INFECTIONS AND OR COMPLICATIONS/PROBLEMS ON THE BACK OF THIS PAGE

➡**PATIENT SIGNATURE**_____ **DATE** _____

FOR OFFICE USE ONLY

HT_____ **WT**_____ **PULSE**_____ **BP**_____ **Notes:**_____

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PATIENT NAME: _____ BIRTHDATE: _____

LIST ALL CURRENT MEDICATIONS & DOSAGE

□Check here if taking NO MEDICATIONS

MEDICATION DOSE FREQUENCY

_____

_____

_____

LIST ALL ALLERGIES & REACTION

□Check here if NO KNOWN ALLERGIES

ALLERGY REACTION

_____

_____

_____

Health Habits

Caffeine: _____cups/day

Alcohol: □ Never □ Social □ ____ drinks per week: □ Beer □ Wine □ Other:_____

Tobacco □ Never □ Currently_____pack(s)/day for _____years □ Cigarette/Cigar □ Pipe □ Chew/ Smokeless □ Quit: When_____

Drug Use: Prescription □ Never □ Recovering □ Current Specify:_____
Recreational □ Never □ Recovering □ Current Specify:_____

Daily Functions: (Check ALL that apply, and answer time period spent per day)

Function			
___ Sitting	Hours per Day___	___ Standing	Hours per Day___
___ Walking	Hours per Day___	___ Bending	Hours per Day___
___ Climbing	Hours per Day___	___ Kneeling	Hours per Day___
___ Kneeling	Hours per Day___	___ Squatting	Hours per Day___
___ Reaching overhead	Hours per Day___		
___ Typing/Writing	Hours per Day___		

___ Lifting	Hours per Day___	___ Minimum Lbs.	___ Maximum Lbs.
___ Pushing	Hours per Day___	___ Minimum Lbs.	___ Maximum Lbs.
___ Pulling	Hours per Day___	___ Minimum Lbs.	___ Maximum Lbs.
___ Carrying	Hours per Day___	___ Minimum Lbs.	___ Maximum Lbs.

➡**Signature**_____ **Date**_____

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Please check if you have the following:

□ Joint Pain	□ Radiculopathy	□ Fractures
□ Back Pain	□ Joint Stiffness	□ Sudden unexplained fractures
□ Loss of appetite	□ Recent change in weight	□ Fatigue (Tired)
□ Fever	□ Chills	□ Night Sweats
□ Headache	□ Vision Problems	□ Ear pain
□ Hearing difficulty	□ Sinus Problems	□ Neck Stiffness
□ Chest Pain	□ Ankle swelling	□ Cold hands or feet
□ Palpitations	□ Heart murmur	□ Persistent cough
□ Shortness of breath	□ Difficulty Breathing	□ Chest congestion
□ Nausea	□ Vomiting	□ Diarrhea
□ Constipation	□ Abdominal Pain	□ Polyuria (Frequent Urination)
□ Excessive Thirst	□ Heat intolerance	□ Cold intolerance
□ Seizures	□ Dizziness	□ Numbness
□ Tingling	□ Confusion	□ Sensory Disturbances
□ Anxiety	□ Depression	□ Panic Attacks
□ Suicidal Thoughts/Attempts	□ Sleep Disturbances	□ Mood Disorders
□ Emotional Problems	□ Depression Screening Completed	□ Easy Bleeding tendency
□ Easy Bruising tendency	□ Frequent Infections	
□ Food Allergy	□ Environmental Allergies	

Preventive Care ***Have you had any of the following? If so, please provide the date.***

□ Last Complete Physical Exam	___/___/___	□ Bone Density	___/___/___
□ Colonoscopy	___/___/___	□ Mammography	___/___/___
□ Flexible Sigmoidoscopy	___/___/___	□ Chlamydia Screening	___/___/___
□ PSA	___/___/___	□ HIV Testing	___/___/___
□ Stool Occult Blood	___/___/___	□ Flu Vaccine	___/___/___
□ Stress Test	___/___/___	□ Pneumovax	___/___/___
□ Routine Eye Exam	___/___/___	□ Zoster Vaccine	___/___/___
□ Dilated Eye Exam	___/___/___	□ Tdap Vaccine	___/___/___
□ Foot Exam	___/___/___	□ TD	___/___/___
□ HPV	___/___/___	□ Tuberculin PPD	___/___/___

Family Health History – (Please Circle: Mother, Father, Sibling)

Mother □ Living □ Deceased Age_____ Cause_____ **Father** □ Living □ Deceased Age_____ Cause_____

□ Ankylosing Spondylitis	M F S	□ Colitis	M F S	□ Kidney Disease	M F S
□ Arthritis	M F S	□ COPD	M F S	□ Liver Disease	M F S
□ Alcoholism	M F S	□ Crohn's Disease	M F S	□ Osteoarthritis	M F S
□ Anemia	M F S	□ CVA / TIA	M F S	□ Osteoporosis	M F S
□ Anxiety	M F S	□ Depression	M F S	□ Psoriasis	M F S
□ Asthma	M F S	□ Diabetes	M F S	□ Pulmonary Disease	M F S
□ Bleeding Disorder	M F S	□ Epilepsy	M F S	□ Renal Disease	M F S
□ CAD	M F S	□ GERD	M F S	□ Rheumatoid Arthritis	M F S
□ MI's	M F S	□ Gout	M F S	□ SLE	M F S
□ CHF	M F S	□ Hypertension	M F S	□ Thyroid Disease	M F S

Signature_____ **Date**_____