The Toledo Clinic

4235 Secor Road
Toledo, OH 43623
419.473.3561
800.444.3561
ToledoClinic.com

Dear_____

We are looking forward to seeing you at your appointment on:

Date _____Please arrive at _____am/pm Appointment @ _____

We have attached forms for you to fill out and bring to the appointment.

We are located in Building 1, Upper Level of the Toledo Clinic. Our telephone number is 419-479-5424

Please note:
If the patient is a minor, he or she will need to be accompanied by his or her legal guardian and we will need his or her social security number.

Co-pays are expected at the time of service, if you are unable to make your co-pay please call to reschedule your appointment

Since we have not seen you before, we would like you to complete a medical history questionnaire. Please complete the questionnaire and bring it with you to your appointment.

Be sure to list all medications (both over the counter and prescription) as well as all drug allergies.

Please bring a CD of any X-ray, CT and MRI with you if they pertain to the problem we are seeing you for. This does **NOT** apply if they were taken at Toledo Clinic locations, Promedica locations and Mercy locations as we are able to view those images electronically. ***If you do not bring outside X-rays/MRI we may need to reschedule your appointment***

If this is a work-related injury, please make sure you have informed our office ahead of time as you need prior authorization to be seen.

We follow the Federal Government/Federal Trade Commission "Red Flag Rules" which require us to see a photo ID and insurance card at each visit.

If you are a new patient to Toledo Clinic or would like to update your information, you can do this online at **www.toledoclinic.com** and go to new patient online registration.

Please be advised that due to our practice being a specialty, there may be a wait. We ask for your patience in the event that a delay in your scheduled time occurs.

If you are unable to keep your appointment, please call at least 24 hours prior to scheduled appointment.

Thank you.

Jason Levine, M D

Jason Levine, M D

Glass City Orthopaedics located in The Toledo Clinic

Department of Orthopaedic Surgery

Patient Name (print):_____Birthdate:_____ Date:_____
Age:_____ ☐ F ☐ M Dominant Hand ☐ R ☐ L
Who requested you to this office? ☐ Doctor_____ ☐ Self-referral ☐Attorney_____

1. *(Chief Complaint) Main reason for visit? ☐ Pain ☐ Numbness ☐Weakness ☐ Other __
2. *(Location) What body part is involved? (Check Below)

Neck ☐ and ☐R arm radiates to ☐L arm	Shoulder ☐R ☐L	Elbow ☐R ☐L	Hand ☐R ☐L	Pelvis ☐R ☐L	Knee ☐R ☐L	Foot ☐R ☐L
Back ☐ and ☐R leg radiates to ☐L leg	Arm ☐R ☐L	Wrist ☐R ☐L	Finger ☐R ☐L	Hip ☐R ☐L	Ankle ☐R ☐L	Toe ☐R ☐L

3. *How long has problem been present?_____ Days _____ Weeks_____ Months _____ Years

4. Check the ONE box below that best describes <u>how your problem started.</u> Then use the space to the right to answer the ONE question below the box you checked. Use as much space as needed.

☐ NO INJURY (onset was:☐ Gradual or ☐Sudden)
Why do you think it started?

☐ INJURY (from Accident or Sport <u>NOT</u> work or Auto)
Date _____, Where and how did it happen?
What sport _____ School _____

☐ INJURY AT WORK (Date _____)
From a ☐lift ☐twist ☐bend ☐pull ☐reach

☐ WORK RELATED (<u>BUT NO INJURY</u>)
Date _____, How did job cause this problem?

☐AUTO ACCIDENT (Date _____) How was car hit?

Answer: Comments:
_____
_____
_____
_____
_____
_____

Please check the box in each category that best describes your problem:

5. *<u>Severity</u> of pain? ☐Mild ☐Moderate ☐Severe ☐Extremely severe
6. *<u>Quality</u> of pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning
7. <u>Timing</u> of pain? ☐Constant ☐Comes & Goes. Does pain wake you from sleep? ☐Y ☐N
8. Do you have? ☐Swelling ☐Bruise ☐Numbness ☐Tingling ☐Weakness ☐Loss of bowel or bladder control
9. Since my problem <u>started</u>, it is: ☐Getting better ☐ Getting worse ☐Unchanged
10. What makes your symptoms <u>worse</u>? ☐Standing ☐Walking ☐Lifting ☐Exercise ☐Twisting ☐ Lying in bed ☐Bending ☐Squatting ☐Kneeling ☐Stairs ☐Sitting ☐Coughing ☐Sneezing
11. What makes it <u>better</u>? ☐Rest ☐Heat ☐Ice ☐Elevation ☐Other
12. What <u>medications</u> have you taken for this problem? _____
13. Which <u>treatment</u> have you tried? ☐Injection ☐Brace ☐Therapy ☐Cane/crutch
14. Were you seen in an <u>Emergency Room</u> for this problem? ☐N ☐Y Which ER and date?_____
15. What <u>tests</u> have you had? ☐X-rays ☐MRI ☐CAT scan ☐Bone scan ☐Nerve test (EMG/NCV)
16. Have you already had <u>surgery</u> for this problem? ☐N ☐Y Surgeons Name_____ Date_____

Family Physician _____Cardiologist_____

Height_____ Weight_____

Do you have a durable power of attorney for healthcare (living will) ___Yes ___No

PAST MEDICAL HISTORY (answering these questions helps the doctor effectively treat your current Orthopaedic problem)

1. Do you take any prescription or non-prescription MEDICATION? ___No ___Yes (list below)

Medication Dose Medication Dose

_____

_____

_____

DO YOU HAVE A HISTORY OF MRSA? _____Yes _____NO

DO YOU TAKE A BLOOD THINNER? ___NO ___YES

2. Are you ALLERGIC to any medication? ___No ___Yes
   Please List your allergies (e.g. eggs, latex, iodine, penicillin ect) and reaction
   _____
   _____

3. FAMILY HISTORY:

   Has any direct relative had any of the following? ___No ___Yes (please mark all that apply)

   Same Orthopaedic condition you are being seen for today ___Rheumatoid arthritis ___Diabetes

   ___High blood pressure ___Heart disease ___Reaction to anesthesia ___Clotting disorder

4. SOCIAL HISTORY
   Do you use tobacco? ___No ___Yes Packs per day ____
   Alcohol use ___No ___Yes How often? ___Daily ___Other _____
   Marital Status: M S D W
   Occupation:_____ Student Employer_____
   Are you currently working? ___Yes ___No If no, how long have you been off work? _____

5. Do you have any MEDICAL PROBLEMS? __No ___Yes(Please circle below)

   Diabetes High Blood Pressure Heart Problems Blood Clots Asthma
   Bronchitis Emphysema Kidney Problems Hepatitis Thyroid Disease
   Ulcers Seizures Stroke Tuberculosis Rheumatoid Arthritis Cancer

6. Have you ever had SURGERY? ___No ___Yes (Please List Details Below)
   Surgery Date Surgery Date
   _____
   _____
   _____
   _____

   HAVE YOU EVER HAD ANY ADVERSE REACTION TO ANESTHESIA? ___No ___ Yes
   Describe_____

REVIEW OF SYSTEMS

Constitutional Symptoms

Have you been in good health lately yes no ___Blurred vision ____Double Vision

____Weight Loss ____Fever ____Loss of Appetite

____ Blurred vision ____Double Vision

ENT

Hearing loss ___ Hoarseness___ Trouble swallowing ___

MUSCULOSKELETAL

Have you ever had a prior problem with the same Orthopaedic condition you are here for today? N Y

Do you have OTHER JOINTS with ___Morning Stiffness ___Swelling ___Pain?

RESPIRATORY

____Chronic Cough ____ Shortness of breath ____Sleep Disorder

CARDIOVASCULAR

___Chest pain ___Palpitations

ENDOCRINE

____Excessive thirst ___Heat or cold intolerance

GASTROINTESTIONAL

____Heartburn ____Nausea ____Vomiting ____Blood in stools

____Stomach pain with anti-inflammatory pills

GENITOUINARY

____Painful Urination ____Blood in Urine

Skin

____Rash ____Skin Ulcers ____Lumps ____Psoriasis

HEMATOLOGY

____Easy Bleeding ____Easy Bruising ____Anemia

____HISTORY OF A BLOOD CLOT

NEUROLOGICAL

____Headaches ____Dizziness

PSYCH

____Depression ____Drug/Alcohol addiction ____

Other_____

Patient Signature_____Date_____

Reviewed by MD_____Date_____

The Toledo Clinic

THE TOLEDO CLINC
4235 Secor Road, Toledo, OH 43623

WORKER'S COMPENSATION WAIVER

PLEASE READ CAREFULLY

By signing this form, you are declaring that the injury or disease for which your Toledo Clinic Orthopedic Department physician is treating you for **is an industrial injury hat occurred while you were on the job or executing a work related activity.**

PRIOR APRROVAL will have to be received from the Bureau of Worker's Compensation before you initial visit, as well as before any surgery and/ or additional treatment can be carried out.

I hereby declare that **my injury is work related** and I authorize Toledo Clinic Orthopedic Department to submit a claim with complete information to my Worker's compensation insurance to issue payment checks directly to Dr.Kristof or Dr.Levine for all payable services. I accept financial responsibility for the medical services I receive today and for any continuous care I receive in the future if not covered by Worker's Compensation for my insurance company.

Patient's Name:_____

Claim Number:_____Date of Injury:_____

Employer's Name and Address at time of injury:_____

Is your employer deputing this claim? _____Yes _____No Is your claim in litigation? ___Yes____No

MCO Company:_____ Case Manager:_____

Allowed Diagnosis code(s): 1._____2._____3._____4._____5._____6._____

Please sign below that this office visit is NOT related to any workers compensation claim.

PLEASE READ CAREFULLY

By signing this form, you declaring that the injury or disease for which you Toledo Clinic Orthopedic Department physician is treating you for **is not an injury and did not occur while you were on the job or executing a work related activity.**

Further, you understand that we will not ever support this injury or disease as industrial injury. You are financially responsible to Toledo Clinic for all charges not covered by you insurance.

Patient Signature:_____ Date:_____