Gregory H. Tchejeyan, M.D., Inc.

Established Patient / New Problem Information

Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

***Please fill in all bubbles completely!**

Patient Name:_____ **Date:**_____

Date of Birth: _____

I. Joint effected: _____

II. Which side is affected? O Right O Left O Bilateral

III. Date of Injury or start of pain (Please be as specific as possible) _____

How did the pain occur? O Injury O Chronic O Spontaneous

If an injury occurred, please explain: _____

Was the injury work related? O Yes O No

Have you ever experienced a similar condition? O Yes O No

If so, please explain: _____

III. Since you were last seen:

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other:_____

Have you had physical therapy? O Yes O No

Are you taking any pain medications?

Anti-inflammatory agent O Yes O No Drug Name: _____

Pain Medication O Yes O No Drug Name:_____

Tylenol O Yes O No

Have you been putting ice on the area? O Yes O No

Have you had any testing? O Yes O No

Which tests? O MRI O EMG/NCS O Bone Scan O CAT Scan

Since your last visit...

Women only: Are you pregnant?	O	Yes	O	No
Have you had ANY surgery?	O	Yes	O	No

If yes, describe (even if it was not to your extremities)_____

Other than your chief complaint have you had any problems with:

A. Tingling or numbness in arms or legs?	O	Yes	O	No
B. Trouble with your heart?	O	Yes	O	No
C. Trouble with your breathing?	O	Yes	O	No
D. Trouble with your bowels?	O	Yes	O	No
E. Trouble with your bladder?	O	Yes	O	No
F. Trouble with your skin?	O	Yes	O	No
G. Have you had a stroke?	O	Yes	O	No
Have you started any new medications?	O	Yes	O	No

If yes, please list medication_____

HAVE YOU HAD ANY NEW MAJOR MEDICAL COMPLICATIONS?

_____

_____

_____

IS THERE ANYTHING NEW ABOUT YOUR HEALTH YOU WOULD LIKE TO ADD?

_____

_____

_____

Patient Signature _____ Date _____