Dean D. Worthingstun ≈ Blue Ridge GA 30513

Last Name: ________________________ First Name: ________________________ Nickname: ________________

Social Security Number: __________________

Date of Birth: ______________________

Gender: M / F Preferred Language: ____________ Ethnic Group: __________ Race: __________

Emergency Contact (name): __________________________ Phone number: ____________________________

Phone Number: Home: ________________________________ Cell: __________________________

Email Address: __________________________________

Mailing Address: ____

City / State: ____ Zip Code: _______________________

Physical Street Address: ____

City / State: ____Zip Code: _______________________

Occupation / Place of Employment: ______________________________

Release of Protected Health Information:_____________________________________ Relationship: _________

Preferred Pharmacy

(Primary - *default*) (Secondary – *if applicable*)

Name: _______________________________________ Name: ____

Phone Number: _____________________________ Phone Number: ______________________________

City or Zip Code: ______________________ City or Zip Code: ______________________________

Primary Care Provider: ___________________________

Referring Physician: ________________________________

Dean D. Worthingstun ≈ Blue Ridge GA 30513

Past Medical History

Name: ________________________________

Select any of the following medical conditions you currently have:

- ○ NONE
- ○ Anxiety Disorder
- ○ Asthma
- ○ Atrial Fibrillation (Irregular heartbeat)
- ○ Benign Prostatic Hyperplasia
- ○ Bipolar Disorder
- ○ Blood Clot (DVT)
- ○ Cerebrovascular Accident (stroke)
- ○ Chronic Anemia
- ○ COPD
- ○ Chronic Pain
- ○ Coronary Arteriosclerosis
- ○ Depressive Disorder/Depression
- ○ Diabetic on Insulin
- ○ Disease caused by 2019-nCoV
- ○ End Stage Renal Disease
- ○ Epilepsy
- ○ Gastroesophageal Reflux Disease
- ○ History of Hypertension (high blood pressure)
- ○ HX of Prim. Hyperparathyroidism
- ○ HX of Radiation therapy
- ○ HIV
- ○ Hypercholesterolemia
- ○ Hyperthyroidism
- ○ Hypothyroidism
- ○ Ischemic Heart Disease
- ○ Left-handed
- ○ Leukemia
- ○ Malignant Lymphoma
- ○ Malignant Tumor of Lung
- ○ Malignant Tumor of Breast
- ○ Malignant Tumor of Colon
- ○ Malignant Tumor of Prostate
- ○ Morbid Obesity
- ○ Multiple Myeloma
- ○ Obesity
- ○ Primary Fibromyalgia Syndrome
- ○ Pulmonary Embolism
- ○ Pulmonary Hypertension due to Diastolic Systemic Ventricular Disfunction
- ○ Right-handed
- ○ Type 2 Diabetes (non insulin)
- ○ Other ____

Dean D. Worthingstun ≈ Blue Ridge GA 30513

Past Surgical History

Have you had any surgeries on the following organs?

- ◯ NONE
- ◯ Bypass of Stomach (Gastric Bypass)
- ◯ Coronary Artery Bypass graft
- ◯ Diverticulitis (Colectomy)
- ◯ Entire Transplanted Kidney
- ◯ Excision of Basal Cell Carcinoma
- ◯ Excision of Melanoma
- ◯ Excision of Squamous Cell Carcinoma
- ◯ H/O Colostomy
- ◯ H/O Tubal Ligation
- ◯ History of Appendectomy (Appendix)
- ◯ History of Cholecystectomy (Gallbladder)
- ◯ History of Colectomy (Diverticulitis)
- ◯ History of Liver Excision
- ◯ History of Mastectomy (Breast)

  SPECIFY: *Right* *Left* *Both*
- ◯ History of Angioplasty
- ◯ Lumpectomy of Breast
- ◯ Mechanical Heart Valve Replacement
- ◯ Pancreas: Pancreatectomy
- ◯ Prostate (Prostatectomy) Prostate Cancer
- ◯ Total Hysterectomy

  Notes:_______________________________________
- ◯ Transplantation of Heart
- ◯ Transplantation of Liver

  Other_______________________________________

Musculoskeletal Disease History

Have you had any of the following?

- ◯ NONE
- ◯ Adhesive Capsulitis of Shoulder
- ◯ Ankylosing Spondylitis
- ◯ Bursitis

  Notes: ____
- ◯ Carpal Tunnel Syndrome

  Notes: ____
- ◯ Chronic Low Back Pain

  Notes: ____
- ◯ Complex Regional Pain Syndrome
- ◯ Compression Fracture of Vertebral Column
- ◯ Epidural Steroid Injections
- ◯ Fracture at Wrist and/or Hand Level
- ◯ Fracture of Ankle

  Notes: ____
- ◯ Fracture of Vertebral Column
- ◯ H/O Hip Fracture
- ◯ Osteoarthritis
- ◯ Osteopenia / DEXA scan Yes or NO
- ◯ Osteoporosis / DEXA scan YES or NO
- ◯ Primary Gout

  Notes: ____
- ◯ Psoriasis with Arthropathy
- ◯ Rheumatoid Arthritis
- ◯ Sarcoma of Bone
- ◯ Sciatica
- ◯ Secondary Malignant Neoplasm of Bone
- ◯ Spinal Stenosis in Cervical Region
- ◯ Spinal Stenosis of Lumbar Region
- ◯ Vitamin D Deficiency

Dean D. Worthingstun ≈ Blue Ridge GA 30513

Musculoskeletal Surgical History

Have you had any of the following?

- ◯ NONE
- ◯ Arthroplasty of Knee
- ◯ Arthroplasty of Shoulder
- ◯ Arthroplasty of the Carpometacarpal Joint of the Thumb (CMC)
- ◯ Arthroscopy of Knee
- ◯ Arthroscopy of Shoulder
- ◯ Cervical Arthrodesis
- ◯ Complete Repair of Rotator Cuff
- ◯ Decompression of Median Nerve
  Carpal Tunnel Release
  SPECIFY: *Right* *Left* *Both*
- ◯ Excision of Bunion
- ◯ Excision of Ganglion Cyst
- ◯ Lumbar Spinal Fusion
- ◯ Release of Trigger Finger
  Notes:
  ____
- ◯ Repair of Ankle
- ◯ Repair of Meniscus
- ◯ Total Knee Replacement
- ◯ Total Replacement of Hip
- ◯ Total Shoulder Replacement
  Other __________________________________
  ____
  ____

Musculoskeletal Family History

Is there a history of any of the following? (*Immediate family)

- ◯ NONE
- ◯ Diabetes
  Notes: __________________________________
- ◯ Hypertension
- ◯ Osteoarthritis
- ◯ Osteoporosis
- ◯ Scoliosis
  Other ____

Social History

Smoking Status (please choose one):

- ◯ Current every day smoker
- ◯ Current someday smoker
- ◯ Former smoker
- ◯ Never smoker
- ◯ Unknown if ever smoked
- ◯ Illicit Drug Use

Alcohol Intake (please choose one):

- ◯ None
- ◯ 1 or less per day
- ◯ 1-2 per day
- ◯ 3 or more per day

How many times in the past year have you had more than 4 drinks in a day? ____________________

Pneumonia Vaccination: Yes / No

Flu Vaccination: Yes / No

Advance Directive: Yes / No

Living Will: Yes / No

Dean D. Worthingstun ≈ Blue Ridge GA 30513

Medications:
Please list ALL current medications *(or check the box if it applies)*

Currently not taking any medication(s)

Medication	Dosage	Frequency

Allergies
Please list ALL known allergies *(or check the box if it applies)*
No Known Allergies (NKA) ****Using the following options, describe your reaction(s) with severity provided below****

Reaction Types			Severity Scale
Anaphylaxis Dizziness Hives Rash Weal	Angioedema Fatigue Liver toxicity Shortness of breath Other: (specify)	Diarrhea GI upset Nausea Swelling	Mild Mild to Moderate Moderate Moderate to Severe Severe Fatal

	Allergy	Reaction(s)	Severity
1.)	____________________	__________________________	_____________________
2.)	____________________	__________________________	_____________________