NEW PATIENT FORM

AIOM Arizona Institute for Osteoporosis Management

1. PERSONAL INFORMATION

Today's Date:

Name:_____Date of Birth_____
First Middle Last

Marital Status: ☐ Single ☐ Married ☐ Live with Partner ☐ Widowed Social Security #:_____-_____-_____

Spouse Name(Parent if Minor):_____ Phone #: _____

Your Mailing Address: _____ City: _____ State: _____ ZIP:_____

Primary Number: _____ ☐ C ☐ W ☐ H Alternate Number: _____ ☐ C ☐ W ☐ H

Email: _____ Occupation: _____

Your Preferred Pharmacy Name: _____ Pharmacy Phone: _____

Primary Care Physician: _____ Primary Care Phone #:_____

Who Referred you to Our Office?: _____ Referring Phone #: _____

2. INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____ Relationship to Patient: _____
Policy Holder's Address (if other than patient's): _____ City:_____ State:_____ ZIP:_____
Policy Holder's Employer Address: _____ City:_____ State: _____ ZIP: _____

Secondary Insurance: _____ ID #: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____ Relationship to Patient: _____
Policy Holder's Address (if other than patient's): _____ City:_____ State:_____ ZIP:_____
Policy Holder's Employer Address: _____ City:_____ State: _____ ZIP: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize all payments of medical benefits to the providers for all services, rendered or to be rendered in the future, without obtaining my signature on each claim. I also authorize the release of any medical information necessary to handle such claims. I UNDERSTAND I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES incurred while I am a patient at Desert Spine and Scoliosis Center, if not covered by my insurance. I hereby confirm that I have read and understand this form.

• **Please Sign Here**: X_____ **Date**: _____

3. INFORMATION RELATED TO YOUR CONDITION AND REASON FOR VISITING OUR OFFICE

Please help us to understand your chief complaint:

What is your primary reason(s) for visiting our clinic, today? _____

Pain: ☐ Yes ☐ No | Location: _____Pain rating: Score 0 = No pain, 10 = Most Severe _____

When did the symptoms first begin? _____ When did the symptoms worsen significantly? (if at all): _____

I feel like my symptoms are (check all that apply): ☐ Getting Worse Fast ☐ Getting Worse Gradually ☐ Not Changing (stable)
☐ Improving ☐ Constant ☐ Often ☐ Sometimes ☐ Few episodes

What makes your condition feel ***better***? _____ ☐ Nothing Helps

What makes your condition feel ***worse***? _____ ☐ Nothing

Fracture Risk Assessment Tool

Age: _____

Gender: ☐ Male ☐ Female

Weight: _____ Height: _____

Previous Fracture **after** age 40: ☐ No ☐ Yes | Details (i.e. Bone, date): _____

Parent has had a Fractured Hip: ☐ No ☐ Yes

Current Smoker: ☐ No ☐ Yes ☐ Previous
(if yes/previous, for how long?:_____ / How many per day?:_____) If previous, year quit: _____
Do you use (check all that apply): ☐ Chewing Tobacco/Dip ☐ Pipes ☐ Cigars ☐ Recreational Drugs

Current/previous Glucocorticoids/Steroids use for **more** than 3 months: ☐ No ☐ Yes

Personal history of Rheumatoid Arthritis: ☐ No ☐ Yes

Personal history of Secondary Osteoporosis: ☐ No ☐ Yes

Do you drink Alcohol? ☐ No ☐ Yes – Avg Daily Amt: _____

Previous DXA scan (Bone Mineral Density Scan): ☐ No ☐ Yes | Date/Location: _____
Femur Neck Bone Mineral Density (BMD from DXA, g/cm²): _____

Handedness: ☐ Left ☐ Right ☐ Ambidextrous

I use an assisted device to get around: ☐ Yes ☐ No | Choose all that apply: ☐ Walker ☐ Cane ☐ Wheelchair ☐ None

Frequent falls: ☐ No ☐ Yes | Believed to be attributed to : ☐ Balance ☐ Dizziness ☐ Other:_____

Spinal Deformity: ☐ No ☐ Yes | Details: ☐ Scoliosis, ☐ Kyphosis ☐ Other::_____

Loss of height: ☐ No ☐ Yes | How much: _____

For Women:

Still having periods/menstrating: ☐ Yes ☐ No | Age at last period, if post-menopausal _____

Current/Previous Hormone replacement/estrogen therapy: ☐ Current ☐ Previous ☐ Never used

Have you had Surgery for a prior fracture? ☐ No ☐ Yes , please describe each surgery below:

- _____: Year_____
- _____ Year:_____
- _____: Year_____
- _____ Year:_____

Other prior surgeries: ☐ No ☐ Yes, please describe each surgery below:

- _____ Year_____ Surgeon_____
- _____ Year_____ Surgeon_____
- _____ Year_____ Surgeon_____

Physical Activity:

I do regular exercise at home: ☐ Yes ☐ No | Briefly describe: _____

I have done Physical Therapy in the past year: ☐ Yes ☐ No | Where: _____

4. PERSONAL/ FAMILY MEDICAL HISTORY- Check all that apply, add additional information if necessary.

MEDICAL CONDITION	YOU	MOTHER	FATHER	MEDICAL CONDITION	YOU	MOTHER	FATHER
HEAD, NECK AND NERVOUS SYSTEM				**HEAD, NECK AND NERVOUS SYSTEM**			
Alzheimer's / Dementia				Liver Problems - Please specify:			
☐ Anxiety / ☐ Panic Attacks				Pancreas Problems - Please specify:			
Depression				Diabetes			
☐ Dizziness / ☐Vertigo				**Thyroid Problems**: ☐Hypo(low) ☐Hyper(high)			
☐Frequent headaches / ☐ Migraines				Kidney Problems - Please specify:			
Multiple Sclerosis				☐Other, specify: i.e. Parathyroid			
Seizures - when was your last?				**REPRODUCTIVE, URINARY AND BOWEL**			
Stroke - Please specify year:				Bladder issues: ☐ Incontinence ☐ Retention			
Glaucoma				Difficulty starting urinary stream			
Changes in vision				Accidental "dribbling"			
☐ Other:				Frequent urination			
HEART AND CIRCULATORY SYSTEM				☐Burning / ☐Strong smelling urine			
Aneurysm				Bowel Issues: ☐ Incontinence ☐ Constipation			
☐ Bleeding condition ☐ Bruise/Bleed Easily				**Chronic Kidney Disease**			
Chest Pain				Sexual Dysfunction (incl. erectile issues)			
☐ Hypertension/High Blood Pressure				Other:			
Heart Disease – Please Specify:				**OTHER**			
High Cholesterol				Calf cramps worse when walking			
Cardiac Stent – Please Specify year:				**Cancer** – Please Specify: ☐Breast ☐Prostate ☐Other			
Heart Attack – Please Specify year:				Fibromyalgia			
☐Other:				Osteo-arthritis			
CHEST AND LUNGS				**Arthritis**: ☐Rheumatoid ☐Psoriatic			
Asthma				Fever/Chills			
☐Emphysema/ ☐COPD				Recent weight change			
Morning Cough				Nausea/ Vomiting			
☐Other:				Other:			

5. Do you have any known allergies to medication? ☐ Yes (please describe below) ☐ No known drug allergies

Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____

Please mark ALL that apply: ☐ N/A ☐ Latex ☐ Adhesive Tape ☐X-Ray/Iodine Contrast Dye ☐Other:_____

6. CURRENT MEDICATIONS **(Please list prescribed and over the counter medications, as well as nutritional supplements and vitamins)**

☐ I have attached a list of my medications to this form.

Calcium: _____ Dose:_____ Reason:_____

Vitamin D: _____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Are there any other important health issues that you feel we should be aware of: ☐ No ☐ Yes

If yes, please explain:_____

_____

7. ALL PATIENTS PLEASE READ AND SIGN THE FOLLOWING

I hereby certify that I have read each question contained on this form. I guarantee that I have answered each question honestly and to the best of my knowledge. I understand that any omission or misrepresentation on my part may seriously jeopardize the ability of my physicians to evaluate and appropriately treat me. I hereby give my permission to the staff of Desert Spine and Scoliosis Center to evaluate and appropriately treat me according to their findings. I hereby authorize all staff at desert Spine and Scoliosis Center to review my responses contained on this form.

Please sign here: X_____ Date:_____