

# OKLAHOMA CENTER FOR ORTHOPAEDIC & SPORTS MEDICINE

M. Sean O'Brien, D.O. | Kevin Mason, PA-C

PLEASE PRINT

## PATIENT INFORMATION

Date		Referring Physician			Referring Physician Phone		
Last			First		Middle		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address				City		State	Zip
Home Telephone ( )		Age	Birthdate / /		Marital Status S M W D DEP		SS# - -
Employer/School		Address		City		State	Zip
Work Phone & Ext. ( )		Cell Phone		Pager		E-Mail	
Patient's Nearest Relative (Other than Spouse)			Relation		Home Phone ( )		Work Phone & Ext. ( )

## RESPONSIBLE PARTY INFORMATION

Spouse/Parent			Relation to Patient			Home Telephone ( )	
Address				City		State	Zip
Employer		SS# - -		Birthdate / /	Age	Work Phone & Ext. ( )	

## INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance				Insurance Type <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Cobra			
Address			City			State	Zip
Insured's Name on Card			I.D. #		Group #		
Insured's Birthdate / /	Patient Relation to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Insured's Sex <input type="checkbox"/> M <input type="checkbox"/> F		Insured's SS# - -		
Insured's Employer					Telephone & Ext. ( )		

Secondary Insurance				Insurance Type <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Cobra			
Address			City			State	Zip
Insured's Name on Card			I.D. #		Group #		
Insured's Birthdate / /	Patient Relation to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Insured's Sex <input type="checkbox"/> M <input type="checkbox"/> F		Insured's SS# - -		
Insured's Employer					Telephone & Ext. ( )		

## OTHER INFORMATION

**I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: Oklahoma Center for Orthopaedic & Sports Medicine. I understand I am financially responsible for any charge not covered by my insurance.**

\_\_\_\_\_  
PATIENT OR AUTHORIZED PERSON

\_\_\_\_\_  
DATE



**Oklahoma Center for  
Orthopaedics & Sports Medicine**

3110 S.W. 89th, Suite 200C  
Oklahoma City, OK 73159  
Fax (405) 759-3827

**M. Sean O'Brien, D.O.**  
**Kevin Mason, PA-C**  
Telephone (405) 759-2663

**NEW PATIENT QUESTIONNAIRE**

DATE:

NAME:		PHONE:	
AGE:	SEX:	HEIGHT:	WEIGHT:
RACE/ETHNICITY:		LANGUAGE:	
FAMILY PHYSICIAN:		REFERRED BY:	
REASON FOR VISIT:		IS THIS INJURY WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
R/L/BIL		OCCUPATION:	

DATE OF ONSET/INJURY(INSURANCE REQUIRES APPROX. DATE) MO. \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_

HAND DOMINANCE RIGHT / LEFT	CURRENT LEVEL OF FUNCTION 0-100 (0 BEING WORST) _____	CURRENT LEVEL OF PAIN 0-10 (10 WORST) _____
--------------------------------	--	--

HAVE YOU SEEN A DOCTOR IN THE PAST FOR THIS PROBLEM? YES/NO WHO, WHEN, WHERE?

EXPLAIN YOUR CONDITION OR HOW YOUR INJURY OCCURRED:

WHAT TREATMENT HAVE YOU HAD? (PLEASE CIRCLE)

REST / MEDICATION / THERAPY / INJECTIONS / OTHER: \_\_\_\_\_

HAVE YOU HAD ANY PREVIOUS DIAGNOSTIC TESTS? (PLEASE CIRCLE)

MRI / X-RAY / CT SCAN / OTHER: \_\_\_\_\_

CIRCLE ANY MEDICAL PROBLEMS LISTED THAT YOU HAVE OR HAVE HAD IN THE PAST:

NO KNOWN MEDICAL PROBLEMS	HIGH BLOOD PRESSURE	HEART DISEASE/HEART ATTACK
LIVER DISEASE/HEPATITIS	DIABETES	COPD/EMPYSEMA
ULCERS	CANCER	TUBERCULOSIS
THYROID DISEASE	IMMUNE DISORDER	BONE INFECTION
PERIPHERAL VASCULAR DISEASE	ASTHMA	SEIZURE DISORDER
STROKE	SLEEP APNEA	OVERWEIGHT / OBESITY
OTHER: _____		

TOBACCO USAGE? YES / NO

PACKS PER DAY \_\_\_\_\_ HOW MANY YEARS \_\_\_\_\_

ALCOHOL USAGE?

NONE / OCCASIONAL / DAILY / >4 DRINKS/DAY

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING?

NONE KNOWN	CANCER	LEUKEMIA	CORONARY ARTERY DISEASE
RHEUMATIC FEVER	DIABETES	HYPOTHYROIDISM	HIGH BLOOD PRESSURE
TUBERCULOSIS	COLITIS	STROKE	BLEEDING TENDENCY
ASTHMA	SEIZURES	OTHER: _____	

WHAT SURGERIES HAVE YOU HAD IN THE PAST?

NO PREVIOUS SURGERY	HYSTERECTOMY	MASTECTOMY	APPENDECTOMY
HERNIA REPAIR	CABG/OPEN HEART	GALL BLADDER	CATARACT EXTRACTION
PROSTATE SURGERY	LUMBAR SPINE SURGERY	TONSILLECTOMY	OTHER: _____



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**REVIEW OF SYSTEMS**

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

PLEASE CIRCLE ALL THAT CURRENTLY APPLY

**GENERAL.**

**CONSTITUTIONAL:**

GOOD GENERAL HEALTH  
RECENT WEIGHT CHANGE  
FATIGUE  
FEVER

**EYES AND VISION:**

WEAR GLASSES/CONTACTS  
BLURRED/DOUBLE VISION  
EYE DISEASE OR INJURY  
GLAUCOMA/CATARACT

**EARS, NOSE, THROAT:**

SWOLLEN GLANDS IN NECK  
EARACHES OR DRAINAGE  
SINUS PROBLEMS  
RINGING IN EARS  
HEARING LOSS  
NOSE BLEEDS

**RESPIRATORY:**

SHORTNESS OF BREATH  
ASTHMA OR WHEEZING  
FREQUENT COUGHING  
SPITTING UP BLOOD

**CARDIOVASCULAR:**

SWELLING OF EXTREMITIES  
IRREGULAR HEARTBEAT  
HEART TROUBLE  
CHEST PAINS

**GASTROINTESTINAL:**

CHANGE IN BOWEL MOVEMENTS  
NAUSEA/VOMITING/DIARRHEA  
LOSS OF APPETITE  
CONSTIPATION  
BLOOD IN STOOL  
ULCERS

**GENITOURINARY:**

BURNING/PAINFUL URINATION  
STRAIN WITH URINATION  
FREQUENT URINATION  
BLOOD IN URINE  
KIDNEY STONES  
INCONTINENCE  
FREQUENT UTI

**MUSCULOSKELETAL:**

JOINT PAIN/STIFFNESS/SWELLING  
WEAKNESS OF MUSCLES/JOINTS  
CHANGE IN HAT OR GLOVE SIZE  
MUSCLE PAIN OR CRAMPS  
DIFICULTY WALKING  
COLD EXTREMITIES  
BACK PAIN

**NEUROLOGICAL:**

LOSS OF CONSCIOUSNESS  
LIGHT HEADED OR DIZZY  
NUMBNESS OR TINGLING  
SEIZURE OR STROKE  
SEVERE HEADACHES  
HEAD INJURY  
PARALYSIS  
TREMORS

**PSYCHIATRIC:**

MEMORY LOSS/CONFUSION  
SLEEP PROBLEMS  
NERVOUSNESS  
DEPRESSION

**ENDOCRINE:**

EXCESSIVE THIRST/URINATION  
GLAND/HORMONE PROBLEM  
HEAT/COLD INTOLERANCE  
CHANGE IN SKIN COLOR  
THYROID DISEASE  
RASH OR ITCHING  
DIABETES  
DRY SKIN

**LYMPHATIC/**

**HEMATOLOGICAL:**

EASILY BRUISE OR BLEED  
SLOW TO HEAL AFTER CUT  
TRANSFUSION REACTIONS  
PHLEBITIS/BLOOD CLOTS  
SWOLLEN GLANDS  
ANEMIA





## PHARMACY INFORMATION

**Please provide us with your preferred pharmacy information. We will only refill prescriptions to the pharmacy we have on file for you.**

**Attn Tricare pts: Please note that we are not able to call-in, fax, or E-prescribe prescriptions to military post/base pharmacies. You we need to provide us with a civilian pharmacy that accepts your insurance.**

**Pharmacy:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**All questions must be filled in. Please do not leave blank.**

**I \_\_\_\_\_ understand that I can only use one pharmacy for prescriptions to be called in from this office.**

**Signature** \_\_\_\_\_