

# Drew A. Stein, MD

## PATIENT INFORMATION SHEET

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_ / \_\_ / \_\_ SS#: \_\_\_\_\_

### ADDRESSES

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Work Address: \_\_\_\_\_  
\_\_\_\_\_  
Occupation: \_\_\_\_\_

### CONTACT NUMBERS

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Email: \_\_\_\_\_

### REFERRAL INFORMATION

Referral Source: \_\_\_\_\_  
Primary MD: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

### INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group#: \_\_\_\_\_  
Insured Name: \_\_\_\_\_  
Insured SS#: \_\_\_\_\_

### INJURY INFORMATION

Date of Injury: \_\_ / \_\_ / \_\_  Work Injury  Auto Accident  Law Suit

Body Part Injured: \_\_\_\_\_

Type of Pain:  Dull  Sharp  Burning  Constant  Radiating

Intensity of Pain: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
*Low Pain* *Moderate Pain* *Intense Pain*

Pain at Night?  Yes  No *describe the pain* \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Previous treatment for this problem? \_\_\_\_\_

### MEDICAL INFORMATION

Current Medical History: \_\_\_\_\_

Previous Surgical History: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Do you smoke Cigarettes?  Yes  No *frequency* \_\_\_\_\_

Do you drink Alcohol?  Yes  No *frequency* \_\_\_\_\_

## REVIEW OF SYSTEMS

Check all that apply and describe any conditions of which the doctor should be aware.

Eyes	<input type="checkbox"/> Glasses	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma
	<input type="checkbox"/> Other _____		
Skin	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Rashes	<input type="checkbox"/> Other _____
Lymphatic	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Other _____	
Ear/Nose/Throat	<input type="checkbox"/> Allergies	<input type="checkbox"/> Other _____	
Neurologic	<input type="checkbox"/> Stroke	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Multiple Sclerosis
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____	
Infectious Disease	<input type="checkbox"/> HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other _____
Cardiovascular	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Blood Pressure
	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Other _____	
Endocrine	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other _____
Genitourinary	<input type="checkbox"/> Chronic Infection	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other _____
Pulmonary	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Bronchitis
	<input type="checkbox"/> Other _____		
Hematologic	<input type="checkbox"/> Anemia	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Other _____
Psychologic	<input type="checkbox"/> Depression	<input type="checkbox"/> Other _____	
Gastrointestinal	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Reflux	<input type="checkbox"/> Crohn's
	<input type="checkbox"/> Other _____		
Constitutional	<input type="checkbox"/> Fever	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Night Sweats
	<input type="checkbox"/> Other _____		
Oncologic	<input type="checkbox"/> Cancer _____		
Musculoskeletal	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other _____
Ob/Gyn	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Other _____	

## FAMILY HISTORY

Advise if any of the family members listed below have/had any of the conditions listed above in the "Review of Systems" section.

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Grandparents

    Maternal: \_\_\_\_\_

    Paternal: \_\_\_\_\_

Siblings: \_\_\_\_\_