Name:
Chart:
Date:

PATIENT INFORMATION SHEET

Today's Date: _____ Appt. with Dr.:

Patient Name (last, first, middle):		
Address:		
City, State, Zip:		
Home Phone Including Area Code:	Cell Phone:	
E-mail Address:		
Birth date: (month, day, year):	**Age:**	
Sex : ☐ Male ☐ Female	Marital Status:	
Social Security Number:	Driver's License Number:	
Patient's Employer:		
Employer's Address:		
City, State, Zip:		
Employer's Phone:		
Primary Insurance Name: '/PRIMARYHEALTHINSCO	Policy ID: '/PRIMINSPOLICYID	Group ID: '/PRIMINSGROUPID
Secondary Insurance Name: '/SECONDARYHEALTHINSCO	Policy ID: '/SECONDARYINSPOLICYID	Group ID: '/SECONDARYINSGROUPID
Responsible Party: (Complete if different from patient or patient is a minor)		
Social Security Number:		
Driver's License Number:		
Birth date: (month, day, year):		
Spouse or Parent's Employer:		
Employer's Address:		
City, State, Zip:		
Employer's Phone:		
Referral Information:		
Who sent you to see us: (First & Last Name)	Relationship:	
Your Family Doctor: (First & Last Name)		

EMERGENCY INFORMATION

Person to notify in case of emergency *other than spouse:*
Address:
City, State, Zip:
Home Phone Including Area Code:
Work Phone:
Relationship:

Name:
Chart:
Date:

Details of Accident or Onset of Symptoms / Illness

Primary Care Provider Name: _____

Primary Care Provider Address: _____

Primary Care Provider Phone: _____

Date of accident or symptoms ___/___/___ What body area was injured _____

Where were you injured:
Work related: **Y or N** Auto Accident: **Y or N** School: **Y or N** Home: **Y or N**

Explain Occurrence of injury or symptoms: _____

_____

_____

_____

Accident location other than home: _____

_____

Have you had an injury of this kind before? Y or N

If yes, explain: _____

_____

Surgeries

_____

_____

Social History

What type of work do you do? _____

Current work status? Full Duty Limited Duty Disabled

Tobacco Products per day? _____ Alcoholic beverages per day? _____

History of substance abuse? Y or N If yes, list drugs taken _____

Right or Left hand dominant Height ___'___" Weight ___lbs

Medications

Please list your medications and the dosages you are taking now. Please include all over the counter medications, vitamins, and herbs.

_____

_____

Pleas list the name and address of your preferred pharmacy. _____

_____

_____

Do you have a Pain Mgmt Physician? ❑ Yes ❑ No If YES, then Name of MD _____

Phone # _____

Name:
Chart:
Date:

Allergies

List any allergies to medications: _____

_____

Other allergies (i.e.: latex, adhesive bandages, topical medications, etc)

_____

_____

Review of Systems

Do you have or have you ever had any of the following conditions?

Describe any problems that you have checked?

AIDS ❑ Yes ❑ No

Asthma ❑ Yes ❑ No

Bleeding Disorder ❑ Yes ❑ No

Cancer ❑ Yes ❑ No

COPD ❑ Yes ❑ No

Dementia ❑ Yes ❑ No

Diabetes Type I ❑ Yes ❑ No

Diabetes Type II ❑ Yes ❑ No

Epilepsy ❑ Yes ❑ No

Hepatitis ❑ Yes ❑ No

High Blood Pressure or Hypertension ❑ Yes ❑ No

Heart Problems ❑ Yes ❑ No If YES, then…

- Cardiologist name: _____
- Cardiac Catherization: ❑ Yes ❑ No
- Echocardiogram: ❑ Yes ❑ No
- Open Heart Surgery: ❑ Yes ❑ No
- Pacemaker: ❑ Yes ❑ No
- Stents: ❑ Yes ❑ No
- Stress test: ❑ Yes ❑ No
- Date of Heart Procedure: _____
- Location of Heart Procedure: _____

Kidney Disorder: ❑ Yes ❑ No

Oxygen Use: ❑ Yes ❑ No

Sleep Apnea: ❑ Yes ❑ No If YES, then…

- Date and place of last Sleep Study _____
- Do you use a C-pap ❑ Yes ❑ No

Thyroid Disorder: ❑ Yes ❑ No

Name:
Chart:
Date:

Family History

List any of your family members who have had the above problems and which specific problem they have had: (to include father, mother, children, brothers, sisters, grandparents):

Print Name _____ Signature _____

Name:
Chart:
Date:

Patient Consent Form: Use or Release of Medical Records

I here give my consent for **First Choice Medical Group, LLC** to use disclose Protected Health Information (PHI) about me to carry our treatment, payment, and healthcare operations (TPO). The Notice of Privacy Practices provided by First Choice Medical Group, LLC describes such uses and disclosures more completely.

I have the right to reviews the Notice of Privacy Practices prior to signing this consent. First Choice Medical Group, LLC reserves the right to revise is notice of privacy practices at any time. A revised notice may be obtained by forwarding in written request to First Choice Medical Group, LLC 709 S. Harbor City Blvd., Melbourne, FL 32901.

With this consent First Choice Medical Group, LLC may call my home or cell phone and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test and radiology reports.

With this consent First Choice Medical Group, LLC may mail my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, test results and patient billing statements.

I have the right to request that First Choice Medical Group, LLC Restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent or later revoke it, First Choice Medical Group, LLC may decline to provide treatment to me.

By signing this form, I am consenting to allow First Choice Medical Group, LLC to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

Patient knows to call or contact a healthcare provider urgently were they to develop bowel or bladder control issues, weakness, coordination changes, balance changes, paralysis, increasing pain or other neurologic changes.

[ ] I, LNAME, 'FNAME _____, authorize the following physician, facility, or hospital _____ to release my medical records to First Choice Medical Group of Brevard (709 S. Harbor City Blvd. Suite 100 Melbourne, FL 32901 Phone: 321-725-0090 x216) [
] fax # _____ [ ] Mail to: _____

[ ] I, LNAME, 'FNAME _____, authorize First Choice Medical Group of Brevard to release my medical records to the following person, physician, facility or hospital: _____ via
[ ] fax # _____ [ ] Mail to: _____ [ ] Pick up by: _____

Signed by: _____ Relationship to Patient: _____

Date: _____

Name:
Chart #:
Date:

PATIENT ACKNOWLEDGEMENT FORM
HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date:_____

☐ **I** _____, do hereby acknowledge receipt of a copy of the HIPAA Notice of Privacy Practices from First Choice Medical Group, LLC.

☐ In the event this request is being made by the individual's personal representative please provide the patient(s) name and Date of Birth below:

Person #1:_____DOB:_____
Person #2:_____DOB:_____

☐ I was offered a copy of First Choice Medical Group, LLC HIPAA Notice of Privacy Practices but declined it.

Patient Signature: _____

Date: _____

Name:
DOB:
Chart:
Age:
Date:

Pain Assessment Sheet for the Spine

I have pain in the (circle all that apply)

Low Back	Low Back & Right Buttock	Low Back & Left Buttock	Neck
Neck & Right Shoulder	Neck & Left Shoulder	Mid-Back	Between Shoulder Blades

My pain is best described as (circle all that apply)

Sharp	Dull	Tingling	Burning	Cramping	Aching
Mild	Severe	Stiffness	Discomfort	Numbness	Tightness

My pain on a scale of 1 to 10 (10 being the worst pain)

0 1 2 3 4 5 6 7 8 9 10

My pain is:	**Better**	**Worse**	**No Change**
In the morning	_____	_____	_____
Bending forward	_____	_____	_____
Sitting in the car	_____	_____	_____
During mid-day	_____	_____	_____
Lying on my stomach		_____	_____
Coughing or Sneezing		_____	_____
Prolonged walking/standing		_____	_____
Prolonged Sitting	_____	_____	_____

Patient Name: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:

UPPER EXTREMITY SYMPTOM AND PAIN QUESTIONARY

Last Name: _____ First Name: _____ MI: _____

Age: _____ Occupation: _____ D.O.B.: _____

Reason of the Visit: _____

Which side? ❑ Right ❑ Left ❑ Both

Approximate date of onset of pain

Describe how you injured your shoulder and/or your upper extremity

Are you? ❑ Right handed ❑ Left handed

Any neck problems? ❑ No ❑ Yes

Rate of pain discomfort (circle one) None 1 2 3 4 5 6 7 8 9 10 Severe

Major Complaint: ❑ pain ❑ loss of motion ❑ slipping out ❑ night pain

❑ grinding ❑ swelling ❑ other _____

Pain is: ❑ Constant ❑ Frequent ❑ Occasional ❑ Sharp

❑ Throbbing ❑ Burning ❑ Electric shot

Location of pain:

❑ front ❑ Back ❑ side ❑ Chest

❑ Up into neck ❑ Down arm into hand.

Pain associated with:

❑ Reaching ❑ Sleeping ❑ Throwing ❑ Overhead activity

❑ None of the above ❑ None of the above, describe _____

Pain relieved by:

❑ Rest ❑ Activity ❑ Heat ❑ Ice ❑ Nothing

❑ Medication, if so which _____

Treatment to date (Check all that apply):

❑ Medication, List: _____

❑ Cortisone injection

❑ MRI/X-Ray When: _____

❑ Physical therapy, if so how long with what result _____

❑ Surgery, describe _____ Surgeon: _____ Date: _____

❑ Other: _____

Are you experiencing numbness in the arm? ❑ Yes ❑ No

Can you dislocate your shoulder on your own? ❑ Yes ❑ No

Patient Signature: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:

LOWER EXTREMITY SYMPTOM AND PAIN QUESTIONARY

Last Name: _____ First Name: _____ MI: _____

Age: _____ Occupation: _____ D.O.B.: _____

Reason of the Visit: _____

Which side? ❑ Right ❑ Left ❑ Both

Approximate date of onset of pain _____

Please indicate which apply: ❑ sport injury ❑ work injury

❑ Motor Vehicle Accident ❑ other, describe

Describe how you injured your Knee and/or lower extremity

Are you? ❑ Right handed ❑ Left handed

Rate of pain discomfort (circle one) None 1 2 3 4 5 6 7 8 9 10 Severe

Major complaint: ❑ pain ❑ swelling ❑ slipping out ❑ locking ❑ loss of motion

❑ grinding ❑ buckling ❑ instability ❑ popping

Other: _____

Pain is: ❑ Constant ❑ Frequent ❑ Occasional ❑ Sharp

❑ Throbbing ❑ Burning ❑ Electric shot ❑ Nothing

Location of Pain:

❑ Front ❑ Back ❑ Knee cap ❑ Inner side

❑ Outer side ❑ All over ❑ Other: _____

Pain associated with:

❑ Rest ❑ Prolonged sitting ❑ Sports ❑ Rising from chair ❑ Weight bearing ❑ Stairs ❑ Kneeling ❑ Squatting

❑ Other _____

Pain relieved by:

❑ Rest ❑ Activity ❑ Heat ❑ Ice ❑ Other, describe _____ ❑ Medication, if so which _____

Distance you can walk without pain: ❑ Unlimited ❑ Short distances, how may blocks _____

❑ How many aisle in supermarket _____ ❑ House bound

Treatment to date (Check all that apply):

❑ Medication, List: _____

❑ Cortisone injection

❑ MRI/X-Ray When: _____

❑ Physical therapy, if so how long with what result _____

❑ Surgery, describe _____ Surgeon: _____ Date: _____

❑ Other: _____

Do you utilize any assisted devices? ❑ No ❑ Yes If yes, which: ❑ Cane ❑ Crutches ❑ Walker ❑ Wheelchair

❑ Other _____

Do you participate in sports? If so, which: _____

Patient Signature: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:

Automobile Accident Questionnaire

Patient Name: _____ Date of Accident: _____

What is your Orthopedic injury or condition resulting from this accident? _____

Were you the ❑ Driver ❑ Front Seat Passenger ❑ Back Seat Passenger

Other: _____ Explain: _____

Were you wearing your seat belt? ❑ Yes ❑ No

Make and Model of vehicle:

Description of accident:

Vehicle motion at impact: ❑ High Speed ❑ Low Speed ❑ At a complete stop

Did Airbags deploy? ❑ Yes ❑ No

Head Trauma or loss of consciousness? ❑ Yes ❑ No

Mechanism of injury. (example, dashboard injury or door frame injury) Please explain: _____

How did you exit the vehicle: ❑ Under my own power ❑ by EMS/Fire rescue

Were you taken to an Emergency Room via EMS/Fire rescue? ❑ Yes ❑ No

If so, which Emergency Room: _____

Were you: Treated and Released from: ❑ ER ❑ PCP ❑ Chiropractor ❑ Neurologist

Treatment to date. Please describe: _____

Was the onset of pain: ❑ Immediate ❑ Next day ❑ Progressive over next week

Diagnostic studies to date: ❑ X-rays ❑ MRI ❑ Bone Scan ❑ CT Scan

Any prior history of injuries to the same extremity? ❑ Yes ❑ No

Additional notes: _____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:

FIRST CHOICE

MEDICAL GROUP of BREVARD, LLC

Anthony Lombardo, MD
Board Certified
Orthopedic Surgeon
Sports Medicine

Daniela Rusovici, MD
Board Certified
Neurology

Donald Vliegenthart, MD
Board Certified
Non-Orthopedic Surgeon

Controlled Substance Therapy Agreement

The long term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit, as well as the possibility of dependence. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or (the "Prescribing Physician"), during his absence, by the covering physician, unless specific authorization is obtained for an exception.
2. I agree to obtain all controlled substances prescribed by the Prescribing Physician at the same pharmacy unless an emergent circumstance arises. Should the need arise to change pharmacies. I shall inform this office.

   YOUR SELECTED PHARMACY IS:

   _____ **PHONE:** _____
3. I shall inform this office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.
4. I hereby authorize the Prescribing Physician to discuss all diagnostic and treatment details with any dispensing pharmacists or other professionals who provide my healthcare, for purpose of maintaining accountability.
5. I shall not share, sell, or otherwise permit others to have access to these medications prescribed by the Prescribing Physician. I acknowledge that these drugs may be hazardous or lethal to other persons and I shall keep them in a secured container, out of reach and out of view of others.
6. I acknowledge that these drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

Name:
DOB:
Chart:
Age:
Date:

7. I acknowledge and understand that unannounced urine or serum toxicology screens may be requested of me, and that my cooperation is required under this agreement. The presence of unauthorized substances or misuse of prescribed medications may result in prompt referral of assessment for addictive disorder or termination from this practice.
8. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen and I complete a police report regarding the theft, an exception may be made.
9. Early refills will generally NOT be given. Renewals are contingent on keeping scheduled appointments. **PLEASE DO NOT PHONE FOR PRESCRIPTIONS AFTER HOURS OR ON WEEKENDS.**
10. Prescriptions may be issued early if the Prescribing Physician or I will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
11. **If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if I was obtaining medications at several pharmacies, or forging prescriptions and/or pill number totals, I consent to waiving all confidentiality and these authorities may be given full access to my records of controlled substances administration.**
12. It is understood that the medical treatment received herein is initially a trial and that continued prescription is contingent on evidence of benefit.
13. I understand the possible side effects related to the use of opioids, which includes confusion or other changes in thinking abilities, nausea, constipation, problems with coordination or balance, sleepiness or drowsiness, aggravation or depression, breathing slowly, vomiting and dry mouth. I understand I must use caution when operating heavy machinery, driving, or working.
14. I affirm that I have full rights and power to sign and be bound by this agreement and that I have read, understand, and accept all of its terms.
15. In signing this agreement, I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by the Prescribing Physician or referral for further specialty assessment. The Prescribing Physician reserves the right to discharge me from the practice if I fail to adhere to the terms of this agreement.

Prescribing Physician Signature Date

Patient Signature Date

Patient Name Printed

709 S. Harbor City Blvd. Suite 100 * Melbourne, Florida 32901 * Office: (321) 725-2225 * Fax: (321) 308-0635
Email: info@myfcmg.com * Web: www.myfcmg.com

Name:
DOB:
Chart:
Age:
Date:

PATIENT QUESTIONNAIRE
First Choice Medical Group of Brevard

Name: _____ **Age:** _____ **Date:** _____

Main reason for visit: _____

Personal/ Family Medical History: Place a check next to the ones that pertain to you or an immediate family member.

	YOU	FAMILY (who)
Cancer:		
Diabetes:		
Heart Disease:		
Cholesterol Problems:		
Depression:		
HIV:		
Migraines:		
Seizures:		
Stroke at early age:		
Kidney problems/stones:		
Liver Disease:		
Lung Disease/Asthma:		
Ulcers:		
Bleeding Disorder/Clots:		
Alzheimer Disease:		
Muscular Disorder:		
Tremors/Parkinson:		
Multiple Sclerosis:		
Other Significant:		

ALLERGIES:

_____
_____
_____
_____
_____

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____

SOCIAL HISTORY:

Occupation: _____
Smoker: Never Yes Ex-Smoker
Alcohol Use: Never Yes No (Quit)
Illicit Drug Use: No Yes

PRIMARY CARE DOCTOR:

Name: _____
Address: _____
Phone Number: _____

PREVIOUS NEUROLOGIST:

_____

PAST SURGERIES:

_____

Name:
DOB:
Chart:
Age:
Date:

Please _____if you have any of the following:

General
- ____Fever
- ____Chills
- ____Significant weight loss

Eyes
- ____Diplopia (Double Vision)
- ____Vision Loss

Ears Nose & Throat
- ____Earache
- ____Tinnitus (Ringing in the ears)
- ____Decreased Hearing
- ____Swallowing Problems

CV
- ____Chest Pain
- ____Palpitations

Respiratory
- ____Shortness of Breath
- ____Cough

GI
- ____Nausea
- ____Vomiting
- ____Change in bowel habits

GU
- ____Incontinence

MS
- ____Joint Pain

Derm
- ____Rash

Neuro
- ____Vertigo
- ____Frequent falls
- ____Frequent Headaches
- ____Slurred Speech

Psych
- ____Memory Loss
- ____Confusion

Endo
- ____Unusual weight change

Hemo
- ____Bleeding tendency
- ____Clots

Allergy
- ____Recurrent Infection

OTHER
- ____Neck/back pain
- ____Passing Out
- ____Tremors
- ____Dry eyes
- ____Fatigue
- ____Numbness/tingling

_____ _____

Patient Signature Date