



Acadiana Center for Orthopedic and Occupational Medicine, LLC

2501 West Pinhook Road

Lafayette, LA 70508

Phone (337) 269-0136 Fax (337) 233-8525

G. Gregory Gidman, M. D.

Cary Hernandez, M. D.

Barry Levet, M.D

Dear Patient,

Please fill out all areas on the form indicated with a box

OR

all areas with an arrow followed by a bracket. 



Thanks for choosing the Acadiana Center for Orthopedic and Occupational Medicine, LLC for your medical needs.

Patient History

Today's Date:

Name: Age Date of Birth Sex:

How did you learn about our office?

Physician who referred you: Phone #:

Address:

Your family physician: Phone #:

Address:

Are you currently being represented by an attorney regarding your injury or do you plan to seek legal assistance? Yes No

Please describe the type of medical problem or symptoms that you are being seen for today: _____

Date your symptoms began: _____

If your symptoms were because of an accident or injury, please explain: _____

Have you ever had a similar injury? _____ Are your symptoms getting worse, better, or staying the same: _____

Indicate the current level of pain on the following scale: (No pain) 1 2 3 4 5 6 7 8 9 10 (Intolerable)

As best you can, describe your symptoms in terms of: Location: _____

Does the pain move or radiate anywhere: _____

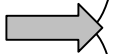
Timing of symptoms (if applicable)	Description of symptoms	Aggravators of symptoms
<input type="checkbox"/> Constant	<input type="checkbox"/> Aches	<input type="checkbox"/> Coughing
<input type="checkbox"/> Occasional	<input type="checkbox"/> Throbs	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Wakes you up	<input type="checkbox"/> Burns	<input type="checkbox"/> Walking
<input type="checkbox"/> With activity	<input type="checkbox"/> Tingles	<input type="checkbox"/> Sleeping
	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Bending or stooping
	<input type="checkbox"/> Numbness	

If you are weak, describe where and the degree of weakness: _____

What helps your condition? _____

Have you had any treatment for your current condition (circle one), did it help?

Physical Therapy	Yes	No	Epidural Steroids	Yes	No
Chiropractic Care	Yes	No	Traction	Yes	No



Patient Name:

Have you had any of the following tests (circle those that apply): MRI X-ray CT Nerve Test Other _____

Has there been any change in bowel or bladder function? Yes No

Are you currently working? Yes No Have you missed any days? Yes No

Do you have now or have you had any of the following:

- | | | | | | |
|---------------------------------------|-----|----|--------------------------------|-----|----|
| a) Hypertension (high blood pressure) | Yes | No | g) Esophageal reflux | Yes | No |
| b) Coronary Artery Disease | Yes | No | h) Gastric ulcer | Yes | No |
| c) Asthma | Yes | No | i) Any type of cancer | Yes | No |
| d) Diabetes | Yes | No | j) Acute myocardial infarction | Yes | No |
| e) Epilepsy or seizure disorder | Yes | No | k) Thyroid disorder | Yes | No |
| f) Hepatitis or liver disorder | Yes | No | l) Stroke | Yes | No |
| Other: _____ | | | | | |

Please list any chronic conditions you have been treated for: _____

Please list all surgeries you have had and the year that they were performed: _____

Please list any medications you are currently taking. List the name of the medication, the frequency and the dosage:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any food or drug allergies? _____

Family History: Has anyone in your immediate family ever had:

- | | | | |
|----------------------------|-----|----|-------------------|
| a) Coronary Artery Disease | Yes | No | If so, who? _____ |
| b) Myocardial Infarction | Yes | No | If so, who? _____ |
| c) Asthma | Yes | No | If so, who? _____ |
| d) COPD | Yes | No | If so, who? _____ |
| e) Thyroid disorder | Yes | No | If so, who? _____ |
| f) Diabetes | Yes | No | If so, who? _____ |
| g) Seizures | Yes | No | If so, who? _____ |
| h) Stroke | Yes | No | If so, who? _____ |
| i) Other (please list) | Yes | No | If so, who? _____ |

Social History:

Are you right-handed or left-handed? (Circle) Race: _____ Marital Status: S M W D

Education level: _____ Who lives in your home? _____

Do you use:

- | | | | |
|------------------|-----|----|-------------------------|
| a) Tobacco | Yes | No | How much per day: _____ |
| b) Alcohol | Yes | No | How much per day: _____ |
| c) Illicit Drugs | Yes | No | How much per day: _____ |

Occupation: _____

Vitals: BP / Pulse _____ Weight _____ Height _____ Temp _____

Patient Name:

REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms? Please check yes or no.

NO **YES **GENERAL****

- Headache
- Fever
- Chills
- Muscle aches
- Diffuse joint pain

NO **YES** **HEENT**

- Sore throat
- Hoarseness
- Earache
- Nasal symptoms
- Loss of hearing

NO **YES** **CARDIOPULOMONARY**

- Chest pain
- Shortness of breath
- Cough
- Difficulty breathing

NO **YES** **GASTROINTESTINAL**

- Nausea
- Vomiting
- Vomiting blood
- Diarrhea
- Constipation
- Red blood in bowel movement
- Red blood on the stool
- Diarrhea bloody
- Black or tarry stools

NO **YES** **MUSCULOSKELETAL**

- Muscle weakness
- Joint swelling, localized
- Neck pain
- Lower back pain
- Bone pain
- Joint pain, localized

NO **YES** **NEUROLOGICAL**

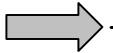
- Limb weakness
- Numbness
- Dizziness
- Fainting
- Confusion
- Speech difficulties
- Difficulties with balance
- Poor coordination

NO **YES** **OTHER**

- Skin symptoms
- Hematologic symptoms
- Endocrine symptoms
- Psychological symptoms

NO **YES** **GENITOURINARY**

- Blood in urine
- Genital lesion
- Vaginal discharge
- Abnormal urethral discharge
- Pain during urination
- Urinary loss of control
- Changes in urinary habits





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PATIENT INFORMATION

PRINT

Patient's Name: (Last) (First) (Mi) Cell #:

Patient's Address: Street City State Zip Phone #:

Social Security #: - - Age: Date of Birth: / /

Sex: M / F Martial Status: S M W D

Patient's Employer: Work Phone: (If Minor, list Parent's Employer)

Alternate Contact Person: Phone #:

Referred By:

Have you seen any of our physicians before or had any services at this clinic? Yes / No If yes, when and for what injury?

Reason for your visit today?

(Type of Injury or Illness): Motor Vehicle Accident, Work Related, Liability, Not an Injury (Please circle)

*****OFFICE USE ONLY*****

INSURANCE INFORMATION

Insurance Name Insurance Phone # Primary Card Holder Primary DOB: - - SS# - - ID / Policy # Group #

VERIFICATION

Effective Date Copay Coinsurance

Reason for visit? Date Symptoms Began: Responsible Party Phone Address: City State Zip



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AUTHORIZATION FOR EVALUATION/TREATMENT AND RELEASE OF MEDICAL FORMS

I hereby authorize any physician of Acadiana Center for Orthopedic and Occupational Medicine to examine and evaluate the patient on the reverse side. I authorize the release of my medical records to any doctor, employer/employer representative, potential employer, insurance company(s), Voc. Rehab, Rehab nurse(s) all information they may request associated with my medical care. I also request that you release my medical records to the physicians of Acadiana Center for Orthopedic and Occupational Medicine.

The opinions rendered in this case are the opinions of the physicians of Acadiana Center for Orthopedic and Occupational Medicine. This evaluation is being conducted on the basis of the medial examination and the documentation provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination, and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

Print Full Name:

Signature:

Date:

ID Checked by _____
(Staff Initials & Date)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and will list any restriction(s) concerning my personal medical information: _____.

List any restriction(s) here

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:

Date: