

**ACI**

**Anderson Clinic, Inc.**

Patient Information Sheet

Office of John L. Albrigo M.D.

**(Please fill out all three pages completely)**

Name \_\_\_\_\_ Age \_\_\_\_\_

Main Problem:(please describe)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Symptoms: (type of pain such as sharp, dull, constant etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Where is the pain? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What makes the pain decrease? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When did the symptoms begin? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there a previous diagnosis of this present condition? Yes / No

If so, what is it? (please describe) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are any other joints affected? Yes / No If so, which ones? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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Is there any history of injury? Yes / No If so, what type of injury was it?

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Please indicate the date of injury? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are present symptoms related to this injury? Yes / No

Is the injury work related? Yes / No (If yes, please give the Insurance carrier name/telephone number/name of agent \_\_\_\_\_

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Who referred you to our office? \_\_\_\_\_

Please provide the name , phone number and address of your primary/family physician? \_\_\_\_\_

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Please provide the name, phone number and address of two people to notify in case of an emergency \_\_\_\_\_

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Please check the appropriate boxes to answer the following questions:

Regarding your current activity level:

- I have pain at rest.
- I am able to walk indoors only.
- I can walk outdoors, but usually less than six blocks at a time.
- I can walk outdoors more than six blocks without too much discomfort.

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Regarding the use of walking aids:

- I do not use a cane or crutches ever.
- I use a cane on occasion.
- I use a cane always.
- I use crutches on occasion.
- I use a crutch or crutches all the time.

Regarding any limitations:

- I (never, sometimes, always) have trouble climbing stairs.
- I (never, sometimes, always) have trouble putting on socks and/or shoes.
- My knee/knees (never, sometimes, always) collapse "gives out" on me.
- My knee/knees (never, sometimes, always) catch or lock when bending it/them.

Do you have previous x-rays of the affected joint? Yes / No If so, where were they taken? \_\_\_\_\_

\_\_\_\_\_ How long ago? \_\_\_\_\_

Did you bring any x-rays with you today? Yes/ No

Please list other major medical problems: \_\_\_\_\_

Please list any recent (within the last 5 years) hospitalizations, (date and reason) \_\_\_\_\_

Please list current medications \_\_\_\_\_

Do you have any know allergies or adverse reactions? \_\_\_\_\_

Do you smoke? Yes/ No



**Anderson Clinic, Inc.**

*"A center of excellence for orthopaedics"*

**MEDICAL INFORMATION RELEASE FORM**

**JOHN L. ALBRIGO, M.D.**

*I, \_\_\_\_\_, hereby authorize Anderson Clinic Inc. and its physicians to furnish and/or obtain from other treating physicians, health care professionals, hospitals and/or insurance carriers information regarding my condition, treatment and account status.*

\_\_\_\_\_  
*Signature of patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

*JLA/ydc*