ARTHRITIS & TOTAL JOINT SPECIALISTS

Name: _____ DOB: _____

Height: _____ Weight: _____ Work Injury: ☐ Y ☐ N Current Occupation: _____

Have you seen another physician regarding this condition? ☐ Y ☐ N If Yes, List name & dates seen _____

_____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY OR HAVE APPLIED) ☐ NO PAST MEDICAL HISTORY

CARDIAC
- ☐ A-FIB
- ☐ CORONARY ARTERY DISEASE (CAD)
- ☐ CONGESTIVE HEART FAILURE (CHF)
- ☐ HEART ATTACK (MI)
- ☐ HEART MURMUR
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL

PULMONARY
- ☐ ASTHMA
- ☐ COPD
- ☐ EMPYHSEMA
- ☐ BRONCHITIS
- ☐ SLEEP APNEA/CPAP
- ☐ BIPAP

ENDOCRINE
- ☐ DIABETES
- ☐ GOUT
- ☐ OBESITY
- ☐ THYROID PROBLEMS

MUSCULOSKELETAL
- ☐ FIBROMYALGIA
- ☐ LUPUS
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPENIA
- ☐ OSTEOPOROSIS
- ☐ RHEUMATOID ARTHRITIS

DERMATOLOGY
- ☐ PSORIASIS

INFECTIOUS DISEASE
- ☐ AIDS/HIV
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ MRSA
- ☐ TUBERCULOSIS (TB)

GASTROINTESTINAL
- ☐ GERD/ACID REFLUX
- ☐ PEPTIC ULCER DISEASE (GASTRIC ULCERS)
- ☐ HERNIA

CANCER
- ☐ CANCER
  TYPE: _____

NEUROLOGICAL
- ☐ STROKE/TIA
- ☐ SEIZURE DISORDER
- ☐ PARKINSON'S DISEASE
- ☐ ALZHEIMER'S DISEASE
- ☐ SPINAL CORD INJURY

GENITOURINARY
- ☐ KIDNEY DISEASE
- ☐ KIDNEY OR BLADDER STONES

HEMATOLOGY/VASCULAR
- ☐ BLEEDING DISORDERS
- ☐ DVT/BLOOD CLOTS
- ☐ PULMONARY EMBOLISM
- ☐ PERIPHERAL VASCULAR DISEASE
- ☐ SICKLE CELL ANEMIA

REPRODUCTIVE: Are you pregnant? ☐ Y ☐ N Last Menstrual Period _____ Are you currently breastfeeding ☐ Y ☐ N

IMMUNIZATION STATUS: Is your immunization status current? ☐ Yes ☐ No ☐ Unknown

METALLIC IMPLANTS: What and where? _____

REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY)

CONSTITUTIONAL
- ☐ FATIGUE
- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

HEENT
- ☐ BLIND/VISUAL IMPAIRED
- ☐ DENTAL PROBLEMS
- ☐ DENTURES
- ☐ GINGIVITIS/GINGIVAL BLEEDING
- ☐ GLASSES OR CONTACTS
- ☐ HEADACHE
- ☐ HEARING AID
- ☐ SINUS PROBLEMS

PULMONARY
- ☐ COUGH
- ☐ SHORTNESS OF BREATH

MUSCULOSKELETAL
- ☐ JOINT PAIN
- ☐ JOINT SWELLING
- ☐ LIMITATION OF ACTIVITY
- ☐ MUSCLE PAIN
- ☐ MUSCLE WEAKNESS
- ☐ RECENT FALLS
- ☐ STIFFNESS
- ☐ UNSTEADY GAIT

SKIN/HEMATOLOGIC/LYMPHATIC
- ☐ ANEMIA
- ☐ CUTS SLOW TO HEAL
- ☐ EASY BRUISE OR BLEED
- ☐ RASHES

GASTROINTESTINAL
- ☐ BLOOD IN STOOL
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ NAUSEA/VOMITING

NEUROLOGICAL
- ☐ DIZZINESS
- ☐ BURNING/NUMBNESS/TINGLING
  WHERE: _____
- ☐ TREMORS

CARDIAC
- ☐ CHEST PAIN
- ☐ IRREGULAR HEART BEATS
- ☐ SWELLING OF HANDS OR FEET

GENITOURINARY
- ☐ BLOOD IN URINE
- ☐ BURNING/PAINFUL URINATION
- ☐ INCONTINENCE

LIST ALL KNOWN ALLERGIES TO MEDICATIONS ☐ NO MEDICATION ALLERGIES

1. _____ REACTION TYPE: _____
2. _____ REACTION TYPE: _____
3. _____ REACTION TYPE: _____

☐ Latex Allergy ☐ PCN ☐ Adhesive Allergy ☐ Poultry /Egg Allergy Other Allergies: _____

HISTORY AND PHYSICAL

CURRENT MEDICATIONS ☐ **NO CURRENT MEDICATIONS**

DRUG NAME	STRENGTH	DOSE	FREQUENCY	PRESCRIBING MD

PAST SURGICAL HISTORY ☐ **NO SURGICAL HISTORY**

- ☐ ADENOIDECTOMY
- ☐ APPENDECTOMY
- ☐ COLON SURGERY
- ☐ BREAST SURGERY
- ☐ HEART BYPASS/CABG
- ☐ CAROTID SURGERY
- ☐ CATARACT SURGERY
- ☐ CESAREAN SECTION (C-Section)
- ☐ GALLBLADDER REMOVAL
- ☐ HEART ANGIOPLASTY
- ☐ HERNIA REPAIR
- ☐ HYSTERECTOMY
- ☐ STENT
- ☐ PACEMAKER
- ☐ SINUS SURGERY
- ☐ TONSILLECTOMY
- ☐ TURP (PROSTATE)
- ☐ IMPLANTABLE PUMPS/OTHER IMPLANT

PAST ORTHOPAEDIC HISTORY ☐ **NO ORTHOPAEDIC HISTORY**

- ☐ ACL RECONSTRUCTION R L
- ☐ AMPUTATION
- ☐ ARTHROSCOPY
  - ☐ HIP: R L
  - ☐ KNEE: R L
  - ☐ SHOULDER: R L
- ☐ BUNIONECTOMY R L
- ☐ CARPAL TUNNEL SYNDROME R L
- ☐ CERVICAL SPINE (NECK) SURGERY
- ☐ FUSION (SPINAL)
- ☐ FASCITIS
- ☐ FASCIECTOMY
- ☐ FRACTURE
- ☐ INJECTIONS
  - ☐ HIP: R L
  - ☐ KNEE: R L
  - ☐ SHOULDER: R L
  - ☐ ELBOW: R L
  - ☐ WRIST: R L
  - ☐ HAND: R L
  - ☐ ANKLE: R L
  - ☐ FOOT: R L
  - ☐ SPINE: R L
- ☐ JOINT FUSION
- ☐ LUMBAR SPINE SURGERY
- ☐ NERVE REPAIR
- ☐ PATELLA DISLOCATION
- ☐ ROTATOR CUFF REPAIR
- ☐ SPINAL STIMULATOR
- ☐ TENDON/LIGAMENT TEARS
- ☐ THORACIC SPINE SURGERY
- ☐ TOTAL HIP REPLACEMENT R L
- ☐ TOTAL KNEE REPLACEMENT R L
  - ☐ UNICOMPARTMENT R L
  - ☐ PATELLOFEMORAL JOINT R L
- ☐ TOTAL SHOULDER REPLACEMENT R L
- ☐ TRIGGER FINGER RELEASE
- ☐ ULNAR NERVE DECOMPRESSION

ANESTHESIA: Any adverse reactions? ☐ Y ☐ N Describe reaction _____

_____

SOCIAL HISTORY

TOBACCO USE: ☐ CURRENT PACKS/DAY: _____ ☐ FORMER ☐ NEVER ☐ CHEWING TOBACCO ☐ VAPE

ALCOHOL USE: ☐ YES ☐ NO IF YES, HOW MUCH PER DAY _____ WHAT TYPE: _____

RECREATIONAL DRUGS: ☐ YES ☐ NO IF YES, WHICH DRUGS: _____

HOBBIES, SPORTS, OR EXERCISE: _____

FAMILY HISTORY ☐ **NO FAMILY HISTORY**

- ☐ ADOPTED: HISTORY UNKNOWN
- ☐ ANEMIA
- ☐ BLEEDING DISORDERS/CLOTTING
- ☐ HIGH CHOLESTEROL
- ☐ STROKE
- ☐ DVT/BLOOD CLOTS/ PULMONARY EMBOLISM
- ☐ OSTEOPOROSIS
- ☐ HEART DISEASE
- ☐ DIABETES
- ☐ CANCER TYPE(S) _____
- ☐ OSTEOARTHRITIS
- ☐ RHEUMATOID ARTHRITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ LUPUS

EMOTIONAL/SPIRITUAL/CULTURAL HISTORY

MENTAL/EMOTIONAL: ☐ ANXIETY ☐ DEPRESSION ☐ RECENT JOB LOSS ☐ DEATH OF SOMEONE CLOSE TO YOU

☐ CURRENTLY UNDER THE CARE OF A PSYCHIATRIST/PSYCHOLOGIST NAME: _____

DO YOU LIVE ALONE? ☐ YES ☐ NO

DO YOU HAVE CONCERNS ABOUT YOUR SAFETY, SAFETY OF ANYONE IN YOUR HOME OR THE SECURITY OF YOUR PROPERTY: ☐ YES ☐ NO

_____ _____

SIGNATURE OF PATIENT **DATE/TIME** **SIGNATURE OF PHYSICIAN** **DATE/TIME**

HISTORY AND PHYSICAL

A Northside Network Provider

English - Spanish

Patient Name: _____ Date of Birth: _____

Physician: _____ Practice Name: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Your Physician has prescribed a treatment plan that includes the use of Controlled Substances, such as opioids (narcotic analgesics), benzodiazepines and barbiturate sedatives. These drugs have a potential for misuse and are therefore controlled by local, state and federal governments. Your treatment plan may include narcotics, intended to reduce the intensity of pain and improve your quality of life, or stimulants given for ADD or ADHD. The narcotic medications are not expected to provide complete pain relief or cure your pain. In order to provide the best quality of care, it is critical for you to be compliant with your treatment program. This agreement is a tool to protect both you, your Physician, and the Practice by establishing guidelines, within the laws, for proper Controlled Substance use.

By signing below, you agree to the following:

1. All Controlled Substances must come from a Physician at the Practice named above unless specific authorization is obtained for an exception. Multiple sources of Controlled Substances or failure to take the medications as prescribed can lead to adverse interactions, overdose, or death.
2. All Controlled Substances must be obtained at the ONE PHARMACY, identified above. Should the need arise to change your pharmacy, the Practice must be informed immediately.
3. The prescribing Physician or his/her delegate has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability. There may be random audits to confirm that you are not receiving Controlled Substances from other sources.
4. No substances with alcohol or illicit substances (marijuana, cocaine, heroin, amphetamines, ecstasy, PCP, etc.) may be used by you, while undergoing medication treatment by the Practice without prior approval from your Physician.
5. You shall take Controlled Substances as prescribed and instructed by your practitioner, unless you develop side effects. If you develop side effects, you must consult with your practitioner or local emergency providers. Any new medications, medical conditions, or adverse reactions to the prescribed medications must be disclosed to the Practice, clinical staff, and providers.
6. You may not share, sell, or otherwise permit others to have access to Controlled Substances prescribed by the Practice physicians. Since the medications may be hazardous or lethal to a person who is not tolerant of their effects, especially a child, you must keep then secured from such persons. Diversion of Controlled Substances will result in dismissal from the Practice.
7. Medications prescribed by Practice physicians should not be stopped abruptly, as this may cause withdrawal symptoms.
8. Urine, serum (blood), or oral fluid (saliva) drug screens, and periodic confirmation testing is required by the Georgia Medical Board to identify compliance with prescribed medication(s) and your treatment plan. Failure to participate may result in immediate dismissal from the Practice.
9. Medications prescribed by the Practice physicians in original containers with remaining doses (pills, capsules, patches, creams, etc.) must be brought to each appointment for the purposes of accountability.
10. Your Physician will prescribe the medication he/she decides is appropriate for your clinical status; he/she is not under any obligation to prescribe any specific medication. Your Physician can wean you off pain medications at any time he/she feels that it is in your best interest.
11. If there is an acute problem (e.g. broken leg, surgery requiring post-op pain medication, dental procedures, etc.), then another doctor may prescribe pain medications to you, but you will advise the prescribing doctor of your care at the Practice and will also notify your Physician of the medication and dosage.
12. Lost, stolen, or destroyed prescriptions will not be replaced.
13. You must agree to safe disposal of unused medications.
14. If legal authorities have questions concerning your treatment, confidentiality is waived and the authorities will be given full access to Practice records, as allowed by law.
15. You agree that Controlled Substance prescriptions, if medically necessary, will be provided on appointment days only. You understand that medication refills or adjustments are done only during office visits. Prescriptions will not be filled early, after normal business hours, on nights and weekends, or over the telephone. An exception may be made at the discretion of your Physician under unusual circumstances. You agree to be seen regularly and keep your appointments. Failure to keep appointments may result in discontinuation of Controlled Substances.
16. You are aware that your Physician will periodically check the Prescription Drug Monitoring Program. You agree to fill any additional forms during your office visits that may be required for risk assessment and compliance monitoring.
17. Practice physicians will not tolerate any disrespectful, abusive or aggressive language, or behavior toward any Practice staff members. Such behavior will result in discharge from the Practice.
18. You must exercise extreme caution when taking Controlled Substances and driving or operating heavy or complex machinery. These medications can cause drowsiness, confusion, or change your mental state and thinking abilities, thereby making it unsafe to drive or operate heavy machinery. If you are the slightest bit impaired, and there is any question of your ability to safely perform these activities, then you must refrain from doing so.
19. You understand that failure to abide by this Agreement may result in discontinuation of treatment and/or discharge from the Practice.
20. You understand that there is a risk you may become addicted to the Controlled Substances you are being prescribed. Your Physician may require you to see a specialist in addiction medicine should a concern about addiction arise.

_____ _____

Witness Date Time AM/PM Signature of Patient or Legally Authorized Representative Date Time AM/PM

_____

Relationship to patient if not the patient

_____ _____

Interpreter Signature / *Firma del intérprete* Reason patient unable to sign

Note: If phone interpretation used, record interpreter ID#

Reorder #28592 PP0091
Piedmont Graphics Rev. 06/04/19

CONTROLLED SUBSTANCES/OPIOID PAIN AGREEMENT