Saurabh Khakharia, MD
Orthopedic Surgery

Please note that this is a requirement for the physician to document this information. Please answer all questions and answer "none" is appropriate.

Pt. Registration:

Date: _____

Last Name: _____ First Name: _____ MI: _____

Age/Sex: _____ Marital Status: _____

Address: _____ Apt. #: ____

City: _____ State: _____ Zip: _____

Phone Number: _____ Birth Date: _____ SSN: _____

Primary Care Physician: _____ Phone Number: _____

Current Pharmacy: _____ Phone number:_____

Responsible Party if minor:

Name: _____ Relationship: _____

Birth Date: _____ Phone #: _____

Patient Employee Information:

Employer: _____ Occupation: _____

Phone Number: _____

Address: _____

_____

_____

Emergency Contact:

Name: _____

Phone Number: _____

Address: _____

_____

Insurance Information:

Primary Insurance: _____

Secondary Insurance: _____

Referral Information:

Who referred you to Dr. Khakharia? _____

Address and Phone number: _____

_____

Chief Complaint:

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

SITE Right Left Both

History of Present Illness:

Severity of pain (in scale of 1-10)

None (0)
Mild (2, 3)
Moderate (4, 5)
Severe (6, 7)
Very Severe (8, 9)
Worst Possible (10)

Where is the pain? _____

Duration of pain? _____

Quality (circle one or more) sharp, dull, aching, shooting, traveling

When did this pain start? _____

Frequency? _____

What causes your pain? _____

What makes it better? _____

Prior treatment? _____

Past Medical History:

- Diabetes
- High Blood Pressure
- Hepatitis/ Jaundice
- HIV/AIDS
- Kidney Disease
- Cardiac Pacemaker
- Anemia
- Cancer
- Reflux/GERD
- Asthma/COPD
- Sleep Apnea
- Stroke/TIA
- Obesity
- History of DVT/PE
- Heart Disease
- Osteoporosis
- Seizures/Fainting
- Chest Pains
- Lung/Respiratory problems, emphysema
- Others: _____

Past Surgical History:

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

Family History:

- Diabetes
- Hypertension
- Heart Disease
- Cancer
- Osteoporosis
- Other: _____

Social History:

Alcohol use: Yes/ No How many drinks per week? _____

Smoking: Yes/ No How many packs per weeks? _____

Drugs: Yes/ No/ In recovery Cocaine Heroin Last use: _____

Activity Level:

- Fitness Center/ Gym
- Sports
- Regular Exercise

Other: _____

Current Medications and what are they used to treat:

1.)_____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

Are you on Aspirin/ Warfarin/ Coumadin/ Heparin/ Plavix/ or any other blood thinner?
_____ (if yes, please circle one)

Allergies to any medications: _____

Other Allergies: _____

Please list any persons and relationships that test results or appointments can be discussed with:

_____

_____

_____