

Helpful Telephone Numbers

Pre-Registration 617-636-0084
Hospital Billing 617-636-4800
Web Address www.tuftsmedicalcenter.org

Pre-Registration

Please call up to 7 days prior to your appointment to pre-register for this appointment. This call typically takes a few minutes. Please have your insurance information available. Insurance plans vary in their requirements. Your plan may require a potential referral, authorization, or out-of-pocket payment for this visit. Pre-registration is available Monday-Friday from 8 AM – 5 PM at 617-636-0084.

Parking

Tufts Medical parking garage is located at 274 Tremont Street. Patients can park in this garage and get their voucher stamped for a discounted parking rate.

Your Appointment is Located
Tufts Medical Center- BIEWEND Building
7th Floor, Orthopaedics Clinic
260 Tremont St, Boston, MA 02111
Ph: 617-636-4548 Fax: 617-636-5178

Patient Instructions

Our patient hours are Monday through Friday 8:00 AM to 5:00 PM. Our phones hours are Monday through Friday 8:30 AM to 5:00 PM. We ask that patients arrive 30 minutes prior to your appointment time in order to prepare you for your visit. Please complete the New Spine Patient Packet, included with this letter, prior to your appointment.

For your comfort during the exam, you may want to bring shorts and a t-shirt or sports bra. ***We require that patients refrain from using creams, scented lotions or perfumes on the day of their visit.***

MRI's or X-rays

If you have any recent MRIs done in the year prior to your visit and they were not performed at Tufts Medical Center, please bring the images and reports to your appointment.

Insurance Referrals

If your insurance requires a referral to see a specialist, you are responsible for obtaining that referral from your Primary Care Physician prior to your appointment and ensuring that we have received it. If the department has not received the referral your appointment will be cancelled or you will be asked to sign a waiver stating that you are aware that you are being seen without a referral and no further appointments or diagnostic tests will be scheduled. Please fax all referrals to 617-636-5178.

Co-Payments

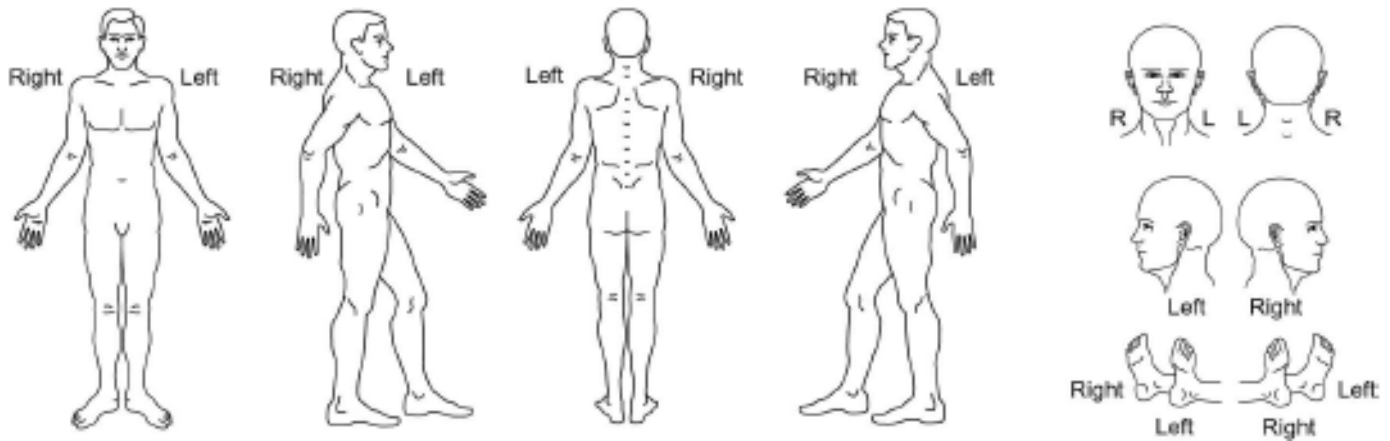
If your insurance requires a copayment, it is due at the time of your visit. We accept payment in the form of a credit card, check, or exact cash amount.

Ambulatory Services
PATIENT HISTORY & ASSESSMENT

PATIENT INFORMATION				
Patient's last name:	First:	Middle:	Birth Date:	Age:
			/ /	
Home Phone no.:	Cell Phone no.:		Business Phone no.:	
()	()		()	
E-Mail Address:				
Height:			Weight:	
PRIMARY CARE PHYSICIAN				
Name	Address		Phone	Fax
REFERRING DOCTOR				
Name	Address		Phone	Specialty
HISTORY OF YOUR PAIN/SYMPTOMS				
Describe in your own words the main problem(s) you would like help with:				
When did your symptoms originally start? / /				
What event(s) led to your original symptoms?				
<input type="checkbox"/> Accident <input type="checkbox"/> Work Injury <input type="checkbox"/> Following an operation <input type="checkbox"/> Cancer <input type="checkbox"/> No Obvious cause <input type="checkbox"/> Other: _____				
Since the time of onset, my symptoms have				
<input type="checkbox"/> Remained the same <input type="checkbox"/> Become more severe <input type="checkbox"/> Become less severe				
What is your ratio of symptoms? (ie: 75% spine, 25% leg)				
_____ % back _____ % neck _____ % leg _____ % arm				
Previous treatment has included (check all that apply)				
<input type="checkbox"/> Medications <input type="checkbox"/> Injections <input type="checkbox"/> Acupuncture <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Pain psychology <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Massage <input type="checkbox"/> Other (specify) _____				

PAIN DIAGRAM

On the body diagram below, Please indicate where your pain is located.



DESCRIPTION OF CURRENT PAIN

Date of current onset / /	Pain frequency <input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes	Pain is worse <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	Your tolerance to pain <input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High
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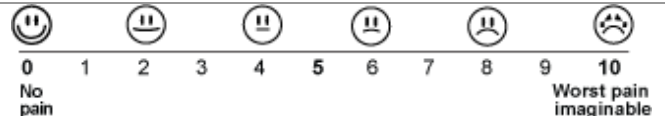
Description of Pain(Check all that apply)

- | | | | | |
|--|-------------------------------|--------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Ache | <input type="checkbox"/> Dull | <input type="checkbox"/> Sharp | <input type="checkbox"/> Sting | <input type="checkbox"/> Tingle |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Deep | <input type="checkbox"/> Superficial | <input type="checkbox"/> Swelling | <input type="checkbox"/> Throb |
| <input type="checkbox"/> Other (please describe) | | | | |

What Relieves Pain (Check all that apply)

- | | | | |
|--|-------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Cold | <input type="checkbox"/> Relaxation Technique | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Heat | <input type="checkbox"/> Repositioning | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Other (please describe) | | | |

On a scale of 0 to 10 with 0 being no pain and 10 being the highest rate your pain now (Circle One)



When I have pain it makes me feel (Check all that apply)

- | | | | | |
|--|--------------------------------|----------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Sad | <input type="checkbox"/> Angry | <input type="checkbox"/> Anxious | <input type="checkbox"/> Tired | <input type="checkbox"/> Helpless |
| <input type="checkbox"/> Other (please describe) | | | | |

What Makes Pain Feel Worse

What Makes Pain Feel Better

PAST MEDICAL HISTORY (Please check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer (specify) _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Psychiatric disorder (specify) _____ |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Autoimmune disorder (specify) _____ | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease | | |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Kidney disease | | |

SURGICAL PROCEDURES

Date	Describe	Hospital Performed	Doctor

CURRENT MEDICATIONS (or attach current medication list)

(Please include prescribed, over-the-counter, herbs and vitamins)

Medication Name	Dose/Frequency	Started	Prescribing MD

ALLERGIES

(Please include medication, food, environment and latex)

Allergy	Reaction

FAMILY HISTORY

Relative	Medical Problem

SOCIAL HISTORY		
What is your occupation ?		
Working Status:		
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time (___ hours per week)	<input type="checkbox"/> Homemaker <input type="checkbox"/> Retired
		<input type="checkbox"/> Unemployed <input type="checkbox"/> Due to pain?
How would you classify your occupation?		
<input type="checkbox"/> Sedentary	<input type="checkbox"/> Light	<input type="checkbox"/> Medium <input type="checkbox"/> Heavy/Physical
Are you on Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Started Reason
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed <input type="checkbox"/> Separated
Do you have any children? If so what ages:		<input type="checkbox"/> No <input type="checkbox"/> Yes
Who do you live with?	<input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Children	<input type="checkbox"/> Roommate(s) <input type="checkbox"/> Pets
Please briefly describe your current living situation (e.g. Apartment with an elevator, or House with 2 floors; stairs)		
Have you experienced significant stress this past year? If yes, please explain:		<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have any pending health related litigations?		<input type="checkbox"/> No <input type="checkbox"/> Yes
BEHAVIORAL HEALTH		
Do you smoke? If yes how much?		<input type="checkbox"/> No <input type="checkbox"/> Yes
How many drinks do you have during a typical week?		_____ drinks / week
Do you use recreational drugs?		<input type="checkbox"/> No <input type="checkbox"/> Yes
FALL RISK ASSESSMENT		
Have you fallen in the last (6) months (not a slip or a trip)?		<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you feeling weak, dizzy, or lightheaded today?		<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you need help to walk or change your clothes?		<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever experienced lightheadedness when having blood drawn or an IV?		<input type="checkbox"/> No <input type="checkbox"/> Yes
FUNCTIONAL STATUS		
Do you use: <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Braces <input type="checkbox"/> Wheelchair <input type="checkbox"/> None of these		
Do you exercise regularly?		<input type="checkbox"/> No <input type="checkbox"/> Yes
What type of exercise do you do?		
How many days per week do you exercise?		
For how long do you exercise each time (approximately)? For running and cycling, please include weekly mileage.		

REVIEW OF SYSTEMS *(Please check all that apply)*

Constitutional

- Weight loss**
- Loss of appetite**
- Fatigue**
- Fever**
- Chills**
- Night sweats**
- Recent Infections**

Eyes

- Blurred vision
- Double vision
- Eye pain or irritation
- Dry eyes

Ears, Nose Mouth and Throat

- Difficulty hearing
- Ringing in Ears
- Dry mouth
- Difficulty swallowing
- Frequent sore throat
- Frequent nose bleeds
- Sinus trouble or congestion

Cardiovascular

- Heart murmur
- Chest pain
- Palpitations
- Shortness of Breath
- Swollen ankles
- Passing out

Endocrine

- Cold hands
- Cold feet
- Excessive thirst
- Excessive urination

Respiratory

- Cough
- Wheezing

Gastrointestinal

- Nausea or vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Ulcers
- Heartburn
- Jaundice (yellow skin)
- Black or Bloody Stools

Genitourinary

- Bladder incontinence**
- Incomplete bladder emptying**
- Genital numbness**
- Frequent or hesitant urination
- Pain with urination
- Blood in urine
- Kidney infection
- Frequent bladder infections
- Erectile dysfunction

Musculoskeletal

- Back pain
- Joint pain
- Joint swelling
- Muscle stiffness

Skin

- Rash/sores
- Eczema
- Psoriasis
- Itching

Neurological

- Headaches
- Loss of strength
- Weakness
- Numbness
- Fainting spells
- Dizziness/vertigo

Psychiatric

- Difficulty sleeping
- Anxiety
- Depression**
- Mood swings
- Memory Loss

Hematological

- Excessive bruising or bleeding
- Enlarged glands

Gynecologic

- Painful periods
- Painful intercourse
- Pregnant
- Post-menopausal
- Last Menstrual Period
Date: _____

Patient signature / Person Completing Form

Date:

Time: