OIP Orthopedic Institute of Pennsylvania Dr. Fernandez	Patient Form Page #
	New Patient Spine Forr
Date of Appointment:	SS:
Name:	
Date of Birth: Age:	
Referring Physician:	
Current Complaint:	
Duration of Complaint:	
Accident: O Yes O No Current Lawsuit: O Yes O No	
	Tall Data:
Spinal Fracture: Ves No Accident Type: MVA OF	-all Date:
Pain: 🔘 Intermittent 🔘 Constant	
Describe Pain: OSharp OBurning OStabbing OTingling O	Achy
Other:	
Pain Intensity On Scale Of 1(least)-10(most):	
Is The Pain: O Improving O Getting Worse O Remaining the S	Same
	Jame
Do You Have Back Pain: 🔘 Yes 🔘 No	
If Yes, Does the Pain Radiate to Your Lower Extremities (Buttocks, Legs, Thighs, or Feet): Yes No	
Location of Your Worst Pain: O Back O Lower Extremities	3
Do You Have Neck Pain: OYes ONo	
If Yes, Does the Pain Radiate to Your Lower Upper	
(Shoulders, Arms, or Hands): Yes No	
Location of Your Worst Pain: O Neck O Upper Extremities	3

Orthopedic Institu of Pennsylvania	ute		indez		Patient For	in rag
					New Patien	nt Spine I
			Date of Appointm	ent:	SS:	
Name:						
Pain Worse With:	OSt	anding (	Sitting OLving	down 🔿 Working 🔿	Walking	
◯ Sleeping ◯ St					J	
Other:	tan s	Jecannig	grotward			
Pain Pottor With:	Oct	anding C		down O Changing Po	sition	
0	0.516				SILION	
Workin		sleepi	ing OStairs O	Leaning Forward		
Other:						
<ul><li>Weakness:</li><li>Incontinence:</li><li>History of Cance</li></ul>	er: 0	Yes ON Bowel O	No Balance Bladder O Non	Disturbance: O Yes Issues: O Yes e	O No O No	
<ul> <li>Weakness:</li> <li>Incontinence:</li> <li>History of Cance</li> <li>Please Explain:</li> <li>Recent Weight Lo</li> </ul>	er: 0	Yes N Bowel O Yes N	No Balance Bladder ONon No	Issues: O Yes e	~	
<ul> <li>Weakness:</li> <li>Incontinence:</li> <li>History of Cance</li> <li>Please Explain:</li> </ul>	er: 0	Yes N Bowel O Yes N	No Balance Bladder O Non No No Height:	Issues: O Yes e Weight:	O No	f
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<ul> <li>Weakness:</li> <li>Incontinence:</li> <li>History of Cance</li> <li>Please Explain:</li> <li>Recent Weight Loo If Yes, How Many</li> <li>Tobacco Use?</li> <li>Alcohol Use?</li> <li>Occupation:</li> </ul>	er: 0 oss: 0 LBS:_	Yes N Bowel O Yes N Yes O	No Balance Bladder None No Height: No - If Yes, Do Y No	Issues: OYes e Weight: /ou - OSmoke OChe Recreational Drug Use	O No ew e? O Yes	O No
<ul> <li>Weakness:</li> <li>Incontinence:</li> <li>History of Cance</li> <li>Please Explain:</li> <li>Recent Weight Loo If Yes, How Many</li> <li>Tobacco Use?</li> <li>Alcohol Use?</li> <li>Occupation:</li> </ul>	oss: C LBS:_ C	Yes N Bowel O Yes N Yes O Yes O Yes O	No Balance Bladder None No Height: No - If Yes, Do Y No	Issues: Yes e Weight: /ou - O Smoke O Cho Recreational Drug Uso Receiving Disabili	O No ew e? O Yes ty? O Yes	O No
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<ul> <li>Weakness:</li> <li>Incontinence:</li> <li>History of Cance</li> <li>Please Explain:</li> <li>Recent Weight Loo If Yes, How Many</li> <li>Tobacco Use?</li> <li>Alcohol Use?</li> <li>Occupation:</li> </ul>	er: 0 oss: 0 LBS:_ 0 Past	Yes N Bowel O Yes N Yes O Yes O Yes O	No Balance Bladder None No Height: No - If Yes, Do Y No	Issues: Yes e Weight: You - O Smoke O Cho Recreational Drug Use Receiving Disabili Treatment Bracing/Collar	No No ew e? Yes ty? Yes Yes	⊖ No