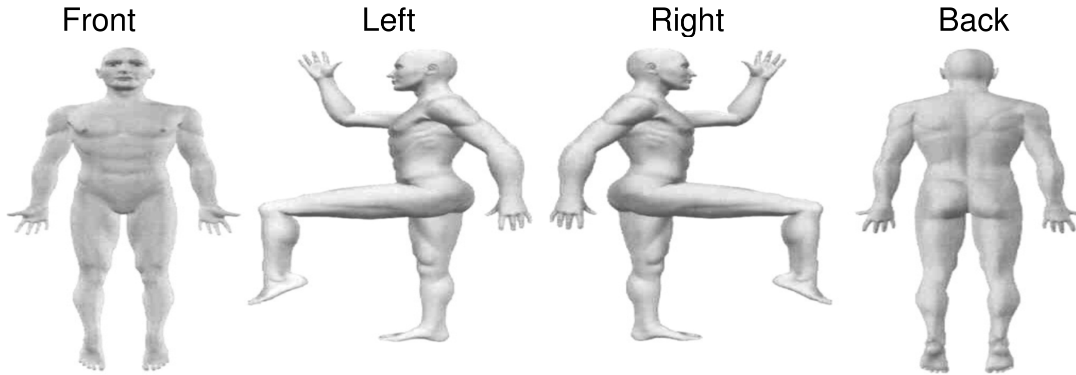
Voytik Center for Orthopedic Care   New / Once a Year

Patient: ____ DOB__________________

Using the diagrams below, shade all the areas of pain completely. Indicate more intense pain with darker markings.



___ Check here If No Pain **G8731
____ **Pain and follow-up plan Documented** ****G8730**

INTENSITY: Please circle the number that best represents your pain level.
Rate your pain **NOW**:
No pain 1 2 3 4 5 6 7 8 9 10 Worse pain
Rate your pain at its **WORSE**:
No pain 1 2 3 4 5 6 7 8 9 10 Worse pain
Rate your pain at its **BEST**:
No pain 1 2 3 4 5 6 7 8 9 10 Worse pain

***QUALITY*: Circle all the words that apply to your pain:**

Aching	Burning
Comes and Goes	Constant
Dull	Numbness
Sharp	Shooting
Stabbing	Tingling

****MEDICATIONS to include herbals, nutritional supplements and over-the-counter drugs.*** *****G8427***

Medication	Dosage	Times a Day	Oral/Topical/Injection		Medication	Dosage	Times a Day	Oral/Topical/Injection

Height ______ Foot ______ Inches   Weight: _______   Total BMI:_______________

Normal: **G8420
Above Normal: **G8417 ____
Below Normal: **G8418

Do you Smoke ____ Yes _____ No   Smoker **4004F Non-Smoker **1036F ____
Do you use Alcohol ____Yes ___No If yes, How much _______   Usage **G9621 Non-Usage **G9622 ____

Are you over the age of 65 and been vaccinated for Pneumonia in the past year? ____ Yes ___ No   Received **4040F
Not Received **4040F-8P ____

If you are over the age of 65 years old and were to become unable to make medical decisions for yourself, who would you grant name as your medical decision maker? Name: ________________________Relationship: _________________   Listed **1123F   Not listed **1124F

Have you received a influenza vaccine in the last year? ____ Yes _____ No   Received **G8482
Not Received:**G8484 ____

Are you over the age of 50? ___Yes ___ No
-Are we currently treating you for a fracture? ___Yes __No**5015F Communication sent to PCP **5015F-8P not communicated
-Have you had a mammogram in the past 24 months? ___Yes___No **3014F results documented **3014F-8P not documented ____
-Have you had a colonoscopy in the past 12 months? ___Yes___No **3017F results documented **3017F-8P not documented ____

********* REQUIRED******MUST BE COMPLETED***   Primary Care Physician ___________________________________

________________________ ________________ ________________________
Patient/Guardian Signature   **Date/Exam Date**   **Provider Signature**