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JORDAN-YOUNG INSTITUTE

ORTHOPEDIC SURGERY • SPORTS MEDICINE
NEUROSURGERY • PHYSICAL MEDICINE & REHABILITATION

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Scott I. Horn, DO
David S. Levi, MD
Ryan C. Coy, MD
Jim McNamara, CEO

Welcome to the Jordan-Young Institute for Orthopedic Surgery, Sports Medicine, Neurosurgery, and Physical Medicine & Rehabilitation. Thank you for choosing us to serve your orthopedic needs. It is our pleasure to assist you in improving your quality of life with medical and surgical options that will maximize your mobility and minimize your pain.

In this packet, you will find both information about our practice and forms you must complete for us to assist in your care. Please read these forms carefully and fully complete each one prior to your appointment. In addition to these completed forms, you will need to bring the following to your appointment:

- Your current insurance cards
- Photo identification
- A referral from your primary care physician, if required by your insurance carrier
- Films and reports from any pertinent diagnostic testing, such as x-rays, MRIs, EMGs, CT scans, and bone density studies
- Any co-payment and deductible payments that your insurance coverage holds you responsible for to receive care. We accept cash, check, VISA, MasterCard, Discover and American Express. Your appointment will be rescheduled if you cannot pay your co-pay before being seen.

PLEASE PLAN TO ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME so that we can

complete your registration, medical record and x-rays prior to your appointment with the physician. Even if you bring x-rays or other diagnostic tests with you, our physicians may require additional films to be taken in our office. Dress in comfortable clothing that will allow your physician to easily view the injured or painful areas of your body. While your physician strives to maintain a timely office schedule; please realize that some wait time may occur. Our physicians will give each patient the time necessary to understand their illness or injury and the options available for treatment.

If you have additional questions about our practice, our providers or your appointment, please visit our website at www.Jordan-YoungInstitute.com. Our office number is (757)490-4802.

DIRECTIONS TO JORDAN-YOUNG INSTITUTE

5716 Cleveland Street, Virginia Beach, VA – (757)490-4802 - www.Jordan-YoungInstitute.com

Jordan-Young Institute is located on Cleveland Street off Newtown Road. Cleveland Street from the Pembroke area ends at Clearfield. There is no direct roadway to Jordan Young Institute on Cleveland Street coming from the east.

FROM NORFOLK/PORTSMOUTH

- Take 264 East
- Exit toward 1-64 E/Chesapeake/Newtown Road
- Take Newtown Road (Exit 15B - stay to the Right when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on the left (the name is on building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

FROM THE BEACH

- Take 264 West
- Exit Newtown Road (Exit 15)
- Turn right onto Newtown Road.
- Turn right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

FROM CHESAPEAKE

- Take Route 64 to Route 264 exit toward Virginia Beach.
- Take Newtown Road (Exit 15B- stay to the Right when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

FROM HAMPTON AND NEWPORT NEWS AREA

- Take 64 East
- Exit Newtown Road. (Exit 284B)
- Take Newtown Road (Exit 15B- stay to the Right when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
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MEDICAL AND SURGICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH:	YES	NO	LIST ANY OTHER MEDICAL CONDITIONS OR TREATMENTS BELOW:
DIABETES TYPE 1 OR TYPE 2			
HYPERTENSION			
ASTHMA			
KIDNEY DISEASE			
ULCERS			
GASTRITIS			
HEPATITIS			
HIV			
SEIZURES			
BLEEDING DISORDERS			
CANCER			

PLEASE LIST ANY PREVIOUS SURGERIES AND THE APPROXIMATE YEAR

SURGERY	YEAR	SURGERY	YEAR

PLEASE LIST ALL MEDICATION ALLERGIES

MEDICATION	REACTION

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) THAT YOU ARE CURRENTLY TAKING

MEDICATION	DOSE	FREQUENCY

FAMILY HISTORY

PLEASE INDICATE THE HEALTH STATUS OF YOUR FAMILY MEMBERS

- | | | |
|----------------|--------------------------------|-----------------------------------|
| MOTHER _____ | <input type="checkbox"/> ALIVE | <input type="checkbox"/> DECEASED |
| FATHER _____ | <input type="checkbox"/> ALIVE | <input type="checkbox"/> DECEASED |
| BROTHER _____ | <input type="checkbox"/> ALIVE | <input type="checkbox"/> DECEASED |
| SISTER _____ | <input type="checkbox"/> ALIVE | <input type="checkbox"/> DECEASED |
| CHILD _____ | <input type="checkbox"/> ALIVE | <input type="checkbox"/> DECEASED |
| CHILD _____ | <input type="checkbox"/> ALIVE | <input type="checkbox"/> DECEASED |
| RELATIVE _____ | <input type="checkbox"/> ALIVE | <input type="checkbox"/> DECEASED |
| RELATIVE _____ | <input type="checkbox"/> ALIVE | <input type="checkbox"/> DECEASED |



JORDAN-YOUNG INSTITUTE

ORTHOPEDIC SURGERY • SPORTS MEDICINE
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REVIEW OF SYSTEMS

CONSTITUTIONAL				GENITOURINARY			
Excessive Fatigue	Yes	No		Difficult Urination	Yes	No	
Exercise Intolerance	Yes	No		Kidney stones	Yes	No	
Chills	Yes	No		Frequency	Yes	No	
Fever	Yes	No		Urgency	Yes	No	
Unexpected weight loss	Yes	No		Flank pain	Yes	No	
Unexpected weight gain	Yes	No		Bleeding	Yes	No	
EYES				Painful urination	Yes	No	
Glaucoma	Yes	No		Bladder infection	Yes	No	
Cataracts	Yes	No		SKIN			
Blurred/double vision	Yes	No		Lesion color change	Yes	No	
Redness	Yes	No		Rash	Yes	No	
Pain	Yes	No		Itching	Yes	No	
ENT				Redness	Yes	No	
Infected or painful teeth	Yes	No		Skin changes	Yes	No	
Headache	Yes	No		Poor healing	Yes	No	
Difficulty swallowing	Yes	No		NEUROLOGICAL			
Nose bleeds	Yes	No		Head injury	Yes	No	
Ringling/Pain in ears	Yes	No		Seizures	Yes	No	
CARDIOVASCULAR				Numbness/tingling	Yes	No	
Chest pain	Yes	No		Stroke	Yes	No	
Heart murmurs	Yes	No		Dizziness	Yes	No	
High blood pressure	Yes	No		Tremors	Yes	No	
Palpitations	Yes	No		HEMATOLOGIC			
Irregular pulse	Yes	No		Easy bleeding/bruising	Yes	No	
Fainting	Yes	No		Blood clots	Yes	No	
Vascular disease	Yes	No		Blood transfusion	Yes	No	
RESPIRATORY				ENDOCRINE			
Asthma	Yes	No		Heat/cold intolerance	Yes	No	
Snoring	Yes	No		Excessive thirst/urination	Yes	No	
Cough	Yes	No		ALLERGIC			
Pulmonary edema	Yes	No		Reaction to foods	Yes	No	
Shortness of breath	Yes	No		Reaction to environment	Yes	No	
Wheezing	Yes	No		PSYCHIATRIC			
Pain with a deep breath	Yes	No		Nervousness	Yes	No	
GASTROINTESTINAL				Anxiety	Yes	No	
Heartburn	Yes	No		Depression	Yes	No	
Nausea	Yes	No		Hallucinations	Yes	No	
Vomiting	Yes	No					
Constipation	Yes	No					
Diarrhea	Yes	No					
Bloody/Tarry Stools	Yes	No					

Patient Signature _____ Date _____

Reviewed with patient

Physician Signature _____ Date _____

