Jack L. Siegel, MD, FAAOS
James E. Dowd, MD, FAAOS
Nicholas A. Midis, MD, FAAOS
Kevin F. Bonner, MD, FAAOS
Louis C. Jordan, MD, FAAOS
Samuel P. Robinson, MD, FAAOS

Louis R. Jordan, MD, Emeritus
David B. Young, MD, Emeritus

JORDAN-YOUNG INSTITUTE

ORTHOPEDIC SURGERY • SPORTS MEDICINE
NEUROSURGERY • PHYSICAL MEDICINE & REHABILITATION

Joseph S. Gondusky, MD, FAAOS
Justin W. Griffin, MD, FAAOS
Jeffrey J. Laurent, MD, FAANS
David A. Vincent, MD, FACS, FAANS
Parker W. Babington, MD, FAANS
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 APPOI NTMENT 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.

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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)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
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NEW PATIENT HISTORY

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT

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TODAY'S DATE ______________________

NAME ____ NICKNAME ______________________________ AGE _______

DATE OF BIRTH ____________________ HEIGHT ______FT _____ IN WEIGHT__________LBS BMI_____________

WHO REFERRED YOU HERE? (NAME/ADDRESS)____

INTERNIST/PCP NAME/ADDRESS ____

CARDIOLOGIST______________________________OTHER SPECIALIST(S)________________________________

REASON FOR YOUR VISIT (HIP/KNEE) ________________LEFT/RIGHT/BOTH FOR ______MONTHS _________YEARS

WHERE IS THE PAIN? FRONT/BACK/INNER/OUTER/ALL OVER ____

WHAT MAKES IT BETTER? ____

WHAT MAKES IT WORSE? ____

HAVE YOU TRIED ANY OF THESE? ☐ BRACING ☐ CANE ☐ WEIGHT LOSS _____# ☐ THERAPY HOW LONG? _______

INJECTIONS? ☐ STEROID LAST:______ HOW MANY____ ☐ VISCO (SYNVISC, EUFLEXXA, ETC) LAST:______ HOW MANY____

ANTI-INFLAMMATORY MEDICATIONS (PAST AND PRESENT – WHICH? ALEVE, ADVIL, CELEBREX, MOBIC, ETC.)

____

HAVE YOU HAD SURGERY ON THIS BODY PART? (Scope or Other and When)______________________________

HAVE YOU HAD A CT SCAN OR MRI OF THIS BODY PART? (WHERE/WHEN) _______________________________

HAVE YOU SEEN OTHER PROVIDERS FOR THIS CONDITION (WHO/WHEN) ________________________________

IS THIS PROBLEM DUE TO AN ACCIDENT? ☐ Y ☐ N IS THIS A WORKERS COMP CLAIM? ☐ Y ☐ N

DATE OF INJURY __________________ WHERE DID THE INJURY OCCUR? ______________________________

HOW DID THE INJURY OCCUR (SPORTS, WORK, MOTOR VEHICLE ACCIDENT)?_____________________________

PAIN AT NIGHT: ☐ Y ☐ N PAIN LEVEL (1-10) ________ DIFFICULTY SLEEPING: ☐ Y ☐ N BACK PAIN: ☐ Y ☐ N

PAIN: MILD MODERATE SEVERE TOTALLY DISABLING **LIMP**: MILD MODERATE SEVERE UNABLE TO WALK

NEED ASSISTANCE: NONE CANE AT TIMES CANE FULL TIME WALKER WHEELCHAIR

HOW FAR CAN YOU WALK? UNLIMITED 6 BLOCKS 2-3 BLOCKS INDOOR ONLY UNABLE

CAN YOU CLIMB STAIRS? NORMALLY NORMALLY WITH THE RAIL WITH DIFFICULTY UNABLE

CAN YOU PUT ON SOCKS AND SHOES? WITH EASE WITH DIFFICULTY UNABLE

WHAT IS YOUR ACTIVITY LEVEL? BEDRIDDEN SEDENTARY SEMI-SEDENTARY LIGHT LABOR MODERATE/HEAVY LABOR

WHAT ARE SOME EXAMPLES OF HOW YOUR PAIN IMPACTS YOUR DAILY LIFE? (THINGS YOU CAN NO LONGER DO OR DO COMFORTABLY) ____

____

CONTINUE TO BACK →

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MEDICAL AND SURGICAL HISTORY

HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE ANY OF THE FOLLOWING?

ANEMIA	ANEURYSM	CARDIAC ARRHYTHMIA	BLOOD CLOTS (DVT/PE)
CAROTID ARTERY DISEASE	CONGESTIVE HEART FAILURE	CARDIAC DISEASE	LUNG DISEASE
DIABETES	GI BLEEDING	GERD/REFLUX	HYPOTHYROIDISM
HEART DISEASE	HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	KIDNEY DISEASE
PEPTIC ULCER DISEASE	PERIPHERAL VASCULAR DISEASE	STROKE/TIA	SEIZURES
ASTHMA	MIGRAINE OR SEVERE HEADACHES	HEPATITIS	HIV
CANCER	EXCESSIVE BLEEDING OR BRUISING	EMPHYSEMA OR COPD	SERIOUS INFECTIONS

PSYCHIATRIC CONDITIONS (DEPRESSION/ANXIETY/OTHER): ______________________

OTHER CONDITIONS: ______________________

DENTAL HISTORY
ANY ACTIVE DENTAL PROBLEMS? □ Y □ N WHAT? ____________ MOST RECENT DENTAL APPOINTMENT ________

PAST SURGICAL TREATMENT (LIST SURGICAL PROCEDURES AND YEAR PERFORMED)

____

____

____

HAVE YOU HAD ANY MAJOR ISSUES (COMPLICATIONS) WITH PRIOR SURGERIES? ____________

SIGNIFICANT FAMILY HISTORY ______________________

MEDICATIONS (LIST NAME, DOSAGE, AND FREQUENCY TAKEN. ATTACH LIST IF NECESSARY)

____

____

____

ALLERGIES (TO MEDICINES OR METALS)

____

____

SOCIAL HISTORY
SINGLE MARRIED WIDOWED
Live with Name____________
Relationship ____________
Retired □ Y □ N Occupation ____________
Tobacco □ Y □ N Packs/day ____________
Alcohol □ Y □ N Drinks/week ____________
Drug use □ Y □ N
Interests/Hobbies____________

____

REVIEW OF SYMPTOMS

Have you experienced any of the following in the past year?

Weight Loss	Weight Gain
Fevers	Vision Changes
Shortness of Breath	Cough
Wheezing	Chest Pain
Irregular Heart Rate	Leg Swelling
Abdominal Pain	Rectal Bleeding
Painful Urination	Difficulty Urinating
Urinary Tract Infections	Severe Back Pain
Leg or Foot Numbness	Leg or Foot Tingling
Easy Bleeding	Skin or Other Infections

Signature ______________________ **Date** ____________