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.

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY - SPORTS MEDICINE
NEUROSURGERY - PHYSICAL MEDICINE & REHABILITATION

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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PATIENT HISTORY

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT

PATIENT NAME_____ TODAY'S DATE _____
LAST FIRST MIDDLE

OCCUPATION _____

DATE OF BIRTH _____ AGE _____ HEIGHT_____ WEIGHT_____

PRIMARY CARE PHYSICIAN'S NAME/ADDRESS _____

REFERRING PHYSICIAN'S NAME/ADDRESS _____

YOUR PRIMARY PROBLEM/COMPLAINT_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT IS THE SEVERITY OF YOUR PAIN (CIRCLE ONE) NONE 1 2 3 4 5 6 7 8 9 10 Unbearable

IS YOUR PAIN: ☐ IMPROVING ☐ WORSENING ☐ STAYING THE SAME

WHAT IMPROVES YOUR SYMPTOMS OR MAKES THEM WORSE?_____

_____

IS THIS A PROBLEM DUE TO AN ACCIDENT? ☐ **YES** ☐ **NO**

IS THIS A WORKERS COMP CLAIM? ☐ **YES** ☐ **NO**

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

_____

WHERE DID THE INJURY OCCUR? _____ **DATE OF INJURY**_____

HAVE YOU HAD X-RAYS, MRIs, or CTs PERFORMED ELSEWHERE RELATED TO THIS PROBLEM? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN _____

HAVE YOU BEEN EXAMINED BY A PHYSICIAN FOR THIS COMPLAINT BEFORE? ☐ YES ☐ NO
IF YES, LIST PHYSICIAN _____

HAVE YOU BEEN TOLD THAT YOU NEED SURGERY, OR EVER HAD SURGERY RELATED TO THIS? ☐ YES ☐ NO
IF YES, LIST PHYSICIAN _____

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW OFTEN/HOW LONG: _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH/OFTEN: _____

HAVE YOU EVER HAD A DRUG ADDICTION? ☐ YES ☐ NO IF YES, HOW LONG AGO: _____

CONTINUE TO BACK →

ORTHOPEDIC SURGERY • SPORTS MEDICINE
NEUROSURGERY • PHYSICAL MEDICINE & REHABILITATION

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 _____ ☐ ALIVE ☐ DECEASED
FATHER _____ ☐ ALIVE ☐ DECEASED
BROTHER _____ ☐ ALIVE ☐ DECEASED
SISTER _____ ☐ ALIVE ☐ DECEASED
CHILD _____ ☐ ALIVE ☐ DECEASED
CHILD _____ ☐ ALIVE ☐ DECEASED
RELATIVE _____ ☐ ALIVE ☐ DECEASED
RELATIVE _____ ☐ ALIVE ☐ DECEASED

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	
Ringing/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** _____

CONTINUE TO BACK →

IF YOUR VISIT IS FOR YOUR HIP OR KNEE, PLEASE COMPLETE THIS FORM

REASON FOR YOUR VISIT – (CIRCLE) HIP KNEE - LEFT RIGHT BOTH _____

WHERE IS THE PAIN? (CIRCLE) FRONT BACK INNER OUTER ALL OVER _____

HAVE YOU TRIED ANY OF THE FOLLOWING? SPECIFY LENGTH OF TIME AND TYPE

☐ THERAPY _____ ☐ HOME EXERCISE _____ ☐ WEIGHT LOSS _____LBS

ASSISTIVE DEVICE ☐ CANE _____ ☐ WALKER _____ ☐ BRACE _____

ANTI-INFLAMMATORY MEDICATION (PREVIOUS AND CURRENT) INCLUDE DURATION OF USE

☐ ALEVE/NAPROXEN _____ ☐ MOTRIN/IBUPROFEN _____ ☐ CELEBREX _____

☐ MOBIC/MELOXICAM _____ ☐ OTHER _____

HAVE YOU HAD INJECTIONS FOR THIS PROBLEM? SELECT ALL THAT APPLY:

☐CORTISONE/STEROID DATE OF LAST INJECTION: _____ HOW MANY TOTAL? _____

☐VISCOSUPPLEMENTATION DATE OF LAST INJECTION: _____ HOW MANY TOTAL? _____
(SYNVISC, EUFLEXXA, HYALGAN)

HAVE YOU HAD SURGERY ON THIS BODY PART? (SCOPE OR OTHER? WHEN?) _____

HAVE YOU HAD ANY OTHER TREATMENT NOT LISTED? _____

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

PAIN AT NIGHT Y OR N **DIFFICULTY SLEEPING** Y OR N **BACK PAIN** Y OR 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

CAN YOU WALK 1/4 OF A MILE (OR 2 CITY BLOCKS) WITHOUT PAIN: Y OR N

CAN YOU CLIMB STAIRS: NORMAL 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)? _____

_____

_____