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
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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)
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MEDICAL QUESTIONNAIRE

Dr. David Vincent

NAME_____ BIRTH DATE _____ TODAY'S DATE_____

IF YOU HAVE BEEN SEEN BY DR. VINCENT BEFORE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. DO YOU HAVE A NEW PROBLEM THAT WAS NOT EVALUATED AT YOUR LAST VISIT? Y N
   IF SO, WHAT IS IT? _____
2. HOW LONG HAS IT BEEN SINCE YOUR LAST VISIT (APPROXIMATELY)? _____ DAYS WEEKS MONTHS
3. SINCE YOUR LAST VISIT, ARE YOU: BETTER WORSE SAME
4. ON A SCALE OF 0-100%, HOW MUCH BETTER ARE YOU NOW? IF NO BETTER, PUT 0%. _____

ALL PATIENTS, PLEASE COMPLETE THE FOLLOWING:

WHAT IS YOUR PAIN LEVEL TODAY? _____
(0=NONE, 10= WORST PAIN IN YOUR LIFE)

1. WHAT IS THE QUALITY OF THE PAIN?
SHARP DULL STABBING THROBBING ACHING BURNING

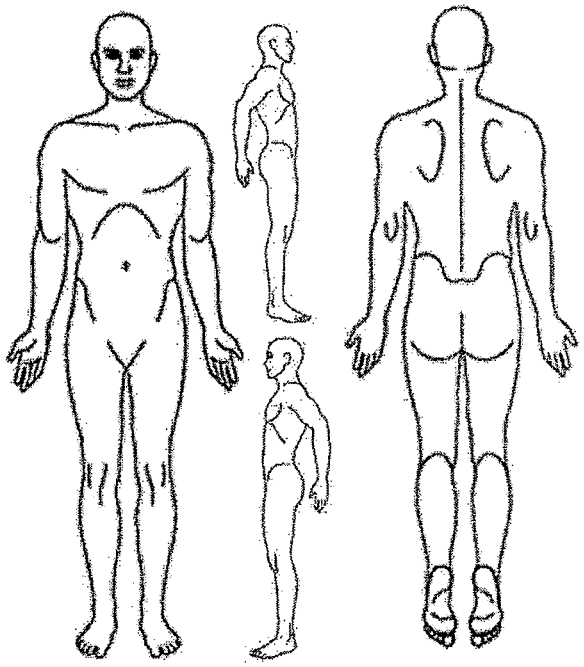
2. THE PAIN IS: CONSTANT COMES AND GOES
3. DOES IT WAKE YOU FROM SLEEP? Y N
4. DO YOU HAVE: NUMBNESS TINGLING WEAKNESS
   LOSS OF BOWEL OR BLADDER NONE
5. WHAT MEDICATIONS ARE YOU TAKING FOR THIS CONDITION? NONE

ANTI-INFLAMMATORY _____(NAME)
PAIN KILLER (NARCOTIC) _____(NAME)

6. INDICATE ANY PRIOR TREATMENT IN THE BOX BELOW:

TREATMENT	DID IT HELP?
ANTI-INFLAMMATORIES	Y N
PHYSICAL THERAPY	Y N
HOME EXERCISE PROGRAM	Y N
INJECTION	Y N
SURGERY	Y N

PLEASE DRAW THE LOCATION OF YOUR PAIN ON THE DIAGRAM. INCLUDE ANY RADIATION TO ARMS OR LEGS.



HISTORY	
CIRCLE ANY PROBLEM AREAS AND DESCRIBE	ALLERGIES NERVES LUNGS EYES SKIN STOMACH/BOWELS OTHER JOINTS DIABETES EARS PSYCHIATRIC WEIGHT LOSS/FEVER HEART URINE ANEMIA
DESCRIBE ANY PROBLEMS:	
ARE YOU PRESCRIBED ANY MEDICATIONS BY ANY OTHER PHYSICIAN? Y N DESCRIBE: _____	
HAVE YOU RECENTLY BEEN HOSPITALIZED? Y N DESCRIBE: _____	
WHAT IS YOUR CURRENT JOB STATUS? REGULAR JOB LIGHT DUTY NOT WORKING DUE TO THIS CONDITION DO NOT WORK RETIRED	
DO YOU HAVE ANY QUESTIONS YOU WOULD LIKE THE DOCTOR TO ANSWER AT THIS VISIT? _____	
PATIENT SIGNATURE _____ MD/PA SIGNATURE _____ DATE _____	

PATIENT HISTORY

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT

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PATIENT NAME_____ TODAY'S DATE _____
LAST FIRST MIDDLE

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 →

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** _____