Kevin Kessler, M.D.
Diplomate American Board of
Orthopaedic Surgery
Board Certified
Naveed Shafi, M.D.
Board Certified

Kessler Sports Medicine Center

Arthroscopic Shoulder,
Knee and Elbow Surgery
Orthopaedic Surgery

Patient Information

Please Print Clearly and Answer ALL Questions

Date: _____ **Is this your first visit?** YES NO

Patient's Legal Name: Last _____First_____ MI_____

Birth date: _____ **Race:** _____ **Language:** _____

Address: _____**Apt:** _____**City:** _____

State: _____ **Zip:** _____**Phone**:_____ **Cell:** _____

Occupation: _____ **Work Phone:** _____

***E-mail Address: (required)** _____

Patient's Social Security Number: _____-_____-_____

Student (circle): Full-time Part-time School: _____

Emergency Contact – Name and Phone #: _____

Insurance Information

Carrier/Company: _____**Phone**:_____ **ID**: _____

Group #:_____**Insured's Full Name**: _____

Relation: _____ **DOB**: _____ **Insured's SSN**: _____/____/_____

Type of Insurance: Medical Auto School

Assignments of Benefits:
I hereby authorize release of information necessary to file a claim to my insurance carrier and ASSIGN BENEFITS otherwise payable to me, to the Doctor or Group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. I hereby authorize my insurance carrier to release any information requested regarding my insurance coverage (eligibility dates, deductible, etc).

Signed: _____ **Date**: _____

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PATIENT QUESTIONAIRE

Today's Date_____

Patient's Legal Name: ***Last***_____***First***_____ ***MI***_____

Birth date: _____ **Age**: _____**Gender** (circle) Male / Female

Main Reason for visit: Pain Swelling Restricted Movement Instability

Other_____

Which Body Part? (Circle) LEFT - RIGHT - BOTH

Shoulder, Elbow, Wrist, Hand, Finger, Hip, Knee, Upper Leg, Lower Leg, Ankle, Foot,

Toe, Heel, Upper Back (Neck), Mid-Back, Lower Back

Have you ever had a prior injury to the area noted above? (Circle) NO – YES if so when? _____

If yes**: How did it happen? _____**

Type of Pain: aching, burning, gnawing, stabbing, throbbing, sharp, dull, occasional, constant,

worsening, improving. Other_____

Severity: no pain, mild, moderate, severe, pain level (1-10) _____

When did you get hurt? ____/____/____ Days Ago ____, Weeks Ago ____, Months Ago ____, Years Ago_____

Timing: acute, chronic (more than 6 weeks), daytime, nighttime, recurrent, intermittent, sudden, overtime

other: _____

How did you get hurt? Fall, bending, lifting, twisting, sports injury (describe) _____,

Work Comp injury (on the job, how did injury occur?) _____; overuse, unsure/unknown,

MVA – How was your vehicle hit? _____ Were you wearing your seat belt? YES NO

Other: _____

4800 North Federal Highway, 3rd Floor Fort Lauderdale, FL 33308 (954) 491-7758 Fax (954) 958-9227
2900 North Military Trail, Suite 230 Boca Raton, FL 33431 (561) 988-0442 Fax (954) 958-9227
Website: www.soflasportsmed.com

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What makes it feel better?

Upper Body – Rest, Lying Down, Ice, Sling, Brace, Splint, Meds, Injections, Stretching, Exercise, PT

Lower Body - Rest, Lying Down, Ice, Heat, Brace, Splint, Elevation, Limited Weight Bearing, Meds, Injections, Stretching, Exercises, PT, Cane, Wheelchair, Walker

What makes the pain worse? Sitting, Standing, Lying Down, Walking, Lifting, Carrying, Twisting, Pushing/Pulling, Gripping, Grasping, Squeezing, Reaching Overhead, Throwing, ROM, Weight bearing, Exercise, Computer Use, Getting out of bed, going from Sit to Stand, Upstairs, Downstairs, Morning, Daytime, Nighttime, Cold Weather, Other_____

What treatment have you tried for the above condition? (Circle): Injection, Ice, Medication, PT, Chiropractor Other_____

If referred to the office, by whom? _____

Primary Care Physician: _____

Address: _____

Phone: _____

Preferred Pharmacy – Name: _____

Address: _____

Phone: _____

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History and Physical Examination

Patients Name: _____Age:_____Height:_____Weight:_____
Presenting Complaint: _____
History of Present Illness: _____
_____
Drug Allergies: _____
Medications:_____
_____
_____

PAST MEDICAL HISTORY

Heart Disease	**Yes**	**No**	**Hepatitis**	**Yes**	**No**	**Cancer**	**Yes**	**No**
Heart Attack	**Yes**	**No**	**Lung Disease**	**Yes**	**No**	**Sickle Cell**	**Yes**	**No**
Atrial Fibrillation	**Yes**	**No**	**Asthma**	**Yes**	**No**	**Rheumatic Fever**	**Yes**	**No**
Murmurs	**Yes**	**No**	**Gout/Pseudo gout**	**Yes**	**No**	**Trauma**	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	**Kidney Disease**	**Yes**	**No**	**Arthritis**	**Yes**	**No**
Stroke	**Yes**	**No**	**Kidney Stones**	**Yes**	**No**	**Osteoporosis**	**Yes**	**No**
Bleeding Disorders	**Yes**	**No**	**GI Disease**	**Yes**	**No**	**Polio**	**Yes**	**No**
Blood Clots or Phlebitis	**Yes**	**No**	**Neuromuscular Disease**	**Yes**	**No**	**HIV**	**Yes**	**No**
Anemia	**Yes**	**No**	**Seizure Disorder**	**Yes**	**No**	**Blood Transfusion Reaction**	**Yes**	**No**
Diabetes	**Yes**	**No**	**Migraine**	**Yes**	**No**	**Psychological (note below)**	**Yes**	**No**
Thyroid Disease	**Yes**	**No**						

Other: _____

PAST SURGICAL HISTORY/HOSPITAL ADMISSIONS

_____
_____
_____

FAMILY HISTORY

_____

Have you or any family member had any complications from anesthesia? _____
_____

SOCIAL HISTORY

Tobacco: (Yes) (No) How much: per day_____ per week_____ Marital Status: M / S / D / Partner / Widowed
Alcohol: (Yes) (No) How much: per day_____ per week_____ Aspirin Use: (Yes) (No) Date Stopped: _____
Substance use: (Yes) (No)

DO NOT write below this line.

REVIEW OF SYSTEMS	PHYSICAL EXAM
	VITALS
To be filled out by Doctor	**GENERAL**
	HEENT
	HEART
	LUNGS
	ABDOMEN
	NEUROMUSCULAR
	EXTREMTIES

IMPRESSION/DIAGNOSIS: _____

PLAN: _____

PHYSICIAN SIGNATURE_____**DATE:**_____

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