



PINNACLE
Orthopedic & Spine Specialists

700 Michigan Ave.
Buffalo, NY 14203

(716) 854.5700 tel
(716) 854.5800 fax

heal@pinnacle-orthopedics.com

Your Appointment is : _____

You must complete this paperwork prior to being seen in our offices.

If you have any questions or concerns, please feel free to contact us at our main office number.

Cameron B. Huckell, M.D.
Adult & Pediatric
Spinal Surgery

Graham R. Huckell, M.D.
Joint Replacement & Arthroscopy
General Orthopedics

A. Marc Tetro, M.D.
Hand, Shoulder & Elbow Surgery,
Arthroscopy & Microsurgery

Kathleen Miller, CPA, MBA
CEO



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PATIENT MEDICAL PROFILE

PATIENT NAME (First, Middle, Last): _____ Pg 1/2

Marital Status: _____ Occupation: _____ Work Status _____

Primary Care Physician _____ Referring Physician _____

PRIMARY COMPLAINT (what is your primary medical problem to be addressed at your first visit):

Medical History Questionnaire:

Sex: ___ M ___ F Height: _____ Weight: _____

Medications: (please list all medications and supplements that you currently take)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (please list all medications that cause allergic reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ___ Yes ___ No If yes: _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No
If yes -- How much _____ How often _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____
_____	_____

Anesthesia Problems with surgery? _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

NO MEDICAL PROBLEMS - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Personal Medical History (continued):

Cardiac / Heart and peripheral vascular disease

- chest pain / angina
- heart attack, myocardial infarction
- congestive heart failure
- other: _____
- high blood pressure
- heart murmur, valve disorder
- mitral valve prolapse
- irregular heartbeat, arrhythmia
- peripheral vascular disease
- deep vein thrombosis
- bleeding problems

Neurologic Disorders

- stroke or TIA
- peripheral neuropathy
- other: _____
- parkinson's
- MS
- cerebral palsy
- polio

Bone & Joint Disorders

- osteoarthritis
- rheumatoid arthritis
- other: _____
- gout
- lupus
- osteomyelitis
- ankylosing spondylitis
- scleroderma

Gastrointestinal Disorders

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed
- diverticulitis
- irritable bowel
- inflammatory bowel disease
- hepatitis - Type _____
- liver disease
- other: _____

Genitourinary Disorders

- urinary tract infection
- bladder problems
- kidney problems
- kidney stones
- dialysis, kidney failure
- other: _____

Metabolic & Other Disorders

- Diabetes x _____ years
- thyroid problems
- sickle cell disease
- high cholesterol or lipids
- skin disorder _____
- psoriasis
- any skin ulcer
- tooth abscess, gingivitis
- depression
- anxiety
- alcohol or drug dependency
- other: _____

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

Family History:

Please indicate with an "X" any significant family medical history or problems.

- asthma
- COPD or Emphysema
- heart attack, myocardial infarction
- bleeding problems
- Peripheral neuropathy
- osteoarthritis
- rheumatoid arthritis
- acid reflux, GERD
- liver disease
- kidney problems
- diabetes
- thyroid problems
- Malignant hyperthermia
- tuberculosis
- other lung : _____
- congestive heart failure
- other heart : _____
- MS or Parkinson's
- Lupus, ankylosing spondylitis
- Other bone & joint: _____
- inflammatory bowel disease
- other GI : _____
- dialysis, kidney failure
- psoriasis
- sickle cell disease
- Anesthesia complications: _____
- sleep apnea
- irregular heartbeat, arrhythmia
- other neuro : _____
- gout
- hepatitis - Type _____
- other: _____
- high cholesterol or lipids
- any skin ulcer

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____



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Patient Name _____
(first) (middle) (last)
Address _____
City, State, Zipcode _____
Telephone _____ Soc. Sec. # _____

Private Health Insurance

PRIMARY

Insurance Co. _____
Address _____
City, State, Zip _____
Telephone _____
Subscriber: _____ Relationship to pt. _____
Date of Birth _____ Employer _____
Patient ID# _____ Group # _____

SECONDARY

Insurance Co. _____
Address _____
City, State, Zip _____
Telephone _____
Subscriber: _____ Relationship to pt. _____
Date of Birth _____ Employer _____
Patient ID# _____ Group # _____

Workers Compensation OR No-Fault Insurance Information

WCB/NF Insurance Co. _____
Insurance Claim # _____ NYS WCB# _____
Address _____
City, State, Zip _____
Telephone _____

EMPLOYER at time of injury _____

Year began employment _____ Date last worked _____
Address: _____
City, State, Zip: _____
Telephone: _____

Date of Injury: _____

Insurance Authorization

I authorize the release of any medical information necessary to process my insurance claims. I also authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy for this form may be used in lieu of the original.

Patient Signature _____