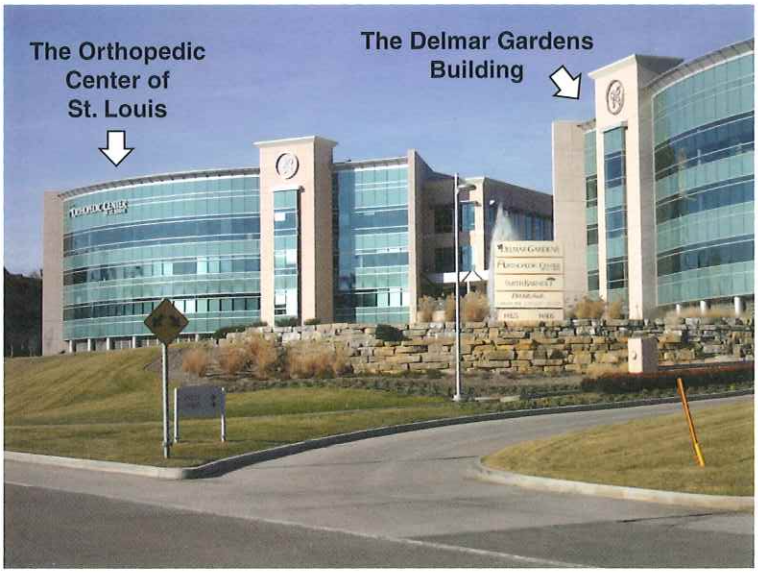
The ORTHOPEDIC CENTER OF ST. LOUIS

Directions To Our Facility

14825 N. Outer Forty Road, Ste 200
Chesterfield, MO 63017
(314) 336-2555

Going 40 East (Coming from St. Charles area) : Exit Timberlake Manor Parkway (Exit 21). Turn left at the stoplight and cross over highway 40. You will immediately come to a second stoplight where you will make a left onto N. Outer Forty Road. Proceed west for 8/10 of a mile. You will pass Bonhomme Presbyterian Church on the right hand side. Prepare to make a right into our entrance. See pictures below of North Outer Forty and our entrance.

Going 40 West (Coming from Downtown St. Louis) : Exit Timberlake Manor Parkway (Exit 21) and merge into the right hand lane, which becomes N. Outer Forty Road. You will eventually come to a stoplight. Go through the stoplight and proceed west for 8/10 of a mile. You will pass Bonhomme Presbyterian Church on the right hand side. Prepare to make a right into our entrance. See pictures below of North Outer Forty and our entrance.



Entrance : Please note that N. Outer Forty Road is a one-way street and our only entrance may be easy to miss if this is your first visit. See the entrance picture above. The only entrance is just before the Delmar Gardens building. Take that entrance and follow it behind the Delmar Gardens building to the second building which is ours.

Dr. Gornet

__New Patient __Update

Date: _____

Patient Legal Name:

(First)_____ (Middle)_____ (Last)_____ Sex: M or F

Social Sec#:_____DOB:_____ Age: _____ Marital Status: M S W D

Address:_____

City, State and Zip: _____

Home Phone: _____ Cell Phone:_____

Employer:_____

Occupation:_____ Work Phone:_____

School Name (if student):_____

Primary Physician Name and Phone:_____

E-mail Address:_____

Emergency Contact: _____

Phone:_____ Relationship:_____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

PATIENT'S NAME:_____ HEIGHT: _____ WEIGHT: _____

TODAY'S DATE: _____ Have you been treated by any of our TOC physicians? _____

MEDICAL INFORMATION

It is important for us to have this information in your file, in case you need emergency care or hospitalization.

PAST MEDICAL HISTORY **GENERAL STATE OF HEALTH:**

How do you rate your current overall health (please circle one)? Excellent Good Fair Poor

If you are an current patient, are there any significant changes since your last visit? Yes No

If so, please explain:_____

GENERAL MEDICAL (Have you had any of the following?)

Past Illnesses:			*Kidney Disease*	Yes	No	*Diabetes*	Yes	No
Heart Disease	Yes	No	*Liver Disease*	Yes	No	*Cancer*	Yes	No
High Blood Pressure	Yes	No	*Hypertension*	Yes	No	*Stroke*	Yes	No

Other Medical Problems: _____

Surgeries/Hospitalizations:

Reason: _____ Admit/Release Date: _____

Reason: _____ Admit/Release Date: _____

Did you have any comlications? Yes No If Yes, Please explain: _____

List any MEDICATIONS and the DOSAGE that you currently take: (Please include any over-the-counter medications)

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

Do you have any known allergies to environmental, food, or drugs? If so, please also list reaction

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

FAMILY HISTORY

Are your parents still alive? Yes No **If not, please list cause of death:** _____ **Age at death:** _____

Are/Were your parents, grandparents, or siblings ever diagnosed with any of the following:

Diabetes	Yes	No	*High Blood Pressure*	Yes	No	*Kidney Disease*	Yes	No
Cancer	Yes	No	*Heart Disease*	Yes	No	*Liver Disease*	Yes	No

SOCIAL HISTORY

Marital Status: (Please circle one) Single Married Divorced Widowed Other

Children? Yes No **If so, how many children?** _____

Are you employed? Yes No **If so, your current employe is?** _____ **Years employed?** _____

Are you disabled? Yes No **If so, when did your diability begin?** _____

Do you smoke? Yes No **Years?** _____ **If so, how many packs per day?** _____

How many alcohol beverages do you drink per week? 0 1 2-5 6 or more

REASON FOR VISIT TODAY:

Describe accident or illness: _____

Is this a work-related injury? Yes No **Date and Time of Injury:** _____

Was an automobile involved? Yes No **First date of treatment:** _____

Was accident/injury reported? Yes No **List providers seen for this illness:** _____

Were x-rays taken? Yes No **Where were x-rays taken?** _____

To the best of my knowledge, the above is a true an accurate account of my medical history:

_____

Patient Signature Date

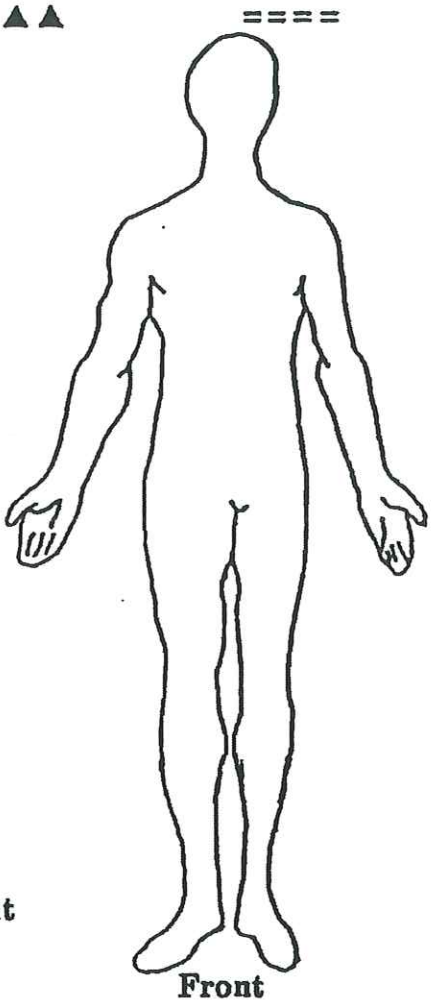
PATIENT PAIN DRAWING

Name: _____ Date: ____/____/____

Where is your pain now?

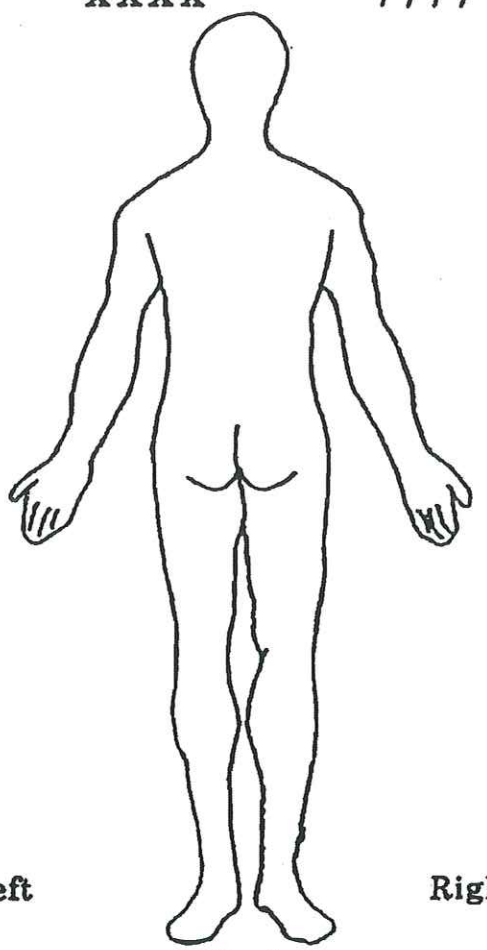
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

ACHING	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
▲▲▲▲	====	OOOO	XXXX	////



Right Left

Front



Left Right

Back

How bad is your pain now?

Please mark with an X on the BODY diagram above where your pain is the worst now.

Please mark on the line below how BAD your pain is now.

No Pain Worst Possible Pain

Paindrawing.rjh 11/99