HOSPITAL FOR SPECIAL SURGERY

James Wyss, MD

WELCOME LETTER FOR DR. JAMES WYSS' PATIENTS

Thank you for choosing Dr. James Wyss as your physician! Below you will find important information that should be read prior to your appointment.

WHAT IS A PHYSIATRIST

Physiatrists are Medical Doctors who specialize in non-surgical physical medicine and rehabilitation (PM&R). They diagnose, treat injuries and conditions, and direct your expanded treatment team using non-surgical methods. The most common methods are physical therapy, minimally invasive injections and certain medications.

ACADEMIC MEDICINE PRACTICE

Dr. Wyss' practice is not a private practice - it is an academic practice. This means that he trains and teaches Residents (post-med school graduates), Fellows and Physical Therapists. Your care will be provided by his team and in his opinion this improves the quality of your care. Integrating teaching and research into a practice takes extra time. This may increase the time need at each visit, and for new patients will increase the time you should expect to be here for your initial visit (approximately 2 hours).

Please let us know if you have any questions about Resident/Fellow/Physical Therapist's role in your exam. If you would prefer a different type of practice or physician please let us know and we will do our best to direct you to another provider.

SERVICES PROVIDED:

Dr. Wyss treats common sports injuries and musculoskeletal conditions and specializes in lumbar spine and hip care in active individuals. He does not specialize in pain management.

Services provided include: a detailed history and physical that helps to establish a specific diagnosis, counseling and patient education, physical therapy and/or exercise prescriptions, ultrasound guided joint, muscle and tendon injections, fluoroscopic guided lumbar spine epidural and facet injections, hyaluronic acid or joint lubricant injections, and PRP (platelet rich plasma) injections. Dr. Wyss also does his best to connect you with other specialists or primary care physicians when you are in need.

New Patient Questionnaire

Physiatry

HOSPITAL FOR SPECIAL SURGERY

Name:	DOB:	Date:
Height:	Weight:	Age:

Which Physician are you here to see today? _____

Referring Physician: _____

Chief Complaint

What is the reason for your visit? _____

_____

_____

Please describe your symptoms:

Aching	Stiffness	Stabbing
Sharp	Dull	Tingling
Catching	Pins and Needles	Other:

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Average Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Pain Level at Best (no pain 0 – 10 highest):

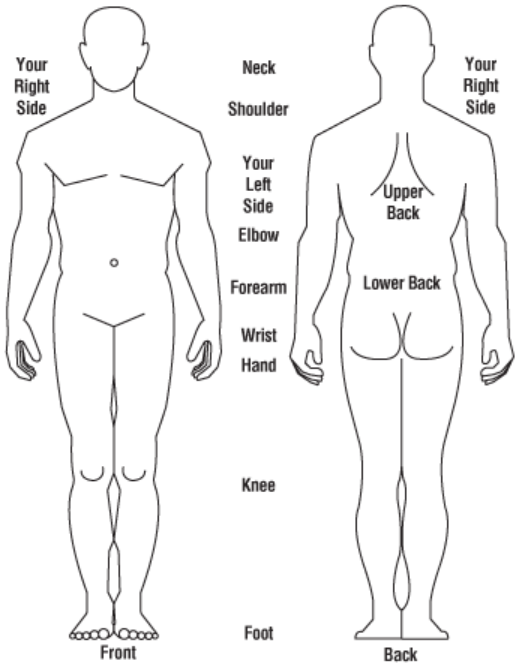
0	1	2	3	4	5	6	7	8	9	10

Pain Level at Worst (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Please mark on the diagram where you are experiencing pain, numbness, and/or tingling.

Use the following symbols on the diagram: Pain = 1, Numbness = 0, Tingling = X



When and how did this condition start? _____

_____

Was this a result of an auto accident? Yes No

Was this a work related injury? Yes No

Do you have a lawsuit related to this? Yes No

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had or tried any of the following treatments for this condition (please select and describe)?

Type	Date Range	Location/Results	Effective?
Medication:			Yes No
Medication:			Yes No
Injection (what kind?):			Yes No
Injection (what kind?):			Yes No
Physical Therapy			Yes No
Surgery			Yes No
Other:			

Have you had any of the following tests for this condition?

Type	Date	Results
X-Ray		
MRI		
CT Scan		
Other:		

Immunizations and Falls Screening (age 65 and older)

Have you received the pneumonia vaccine? Yes No

If yes, date?_____ If not, why?_____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No

If yes, date?_____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Allergies and Medications

Please list any allergies and reactions if known:

Allergy	Reaction
1.	
2.	
3.	

Please list your current medications (including vitamins and supplements):

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medical History

Please list your past or current medical conditions below (even if controlled, e.g. high blood pressure):

_____

_____

_____

Family History

Please list any medical conditions of your family members (mother, father, etc.)

_____

_____

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Social History

Are you a tobacco user?	Yes No	How many packs per day?
Do you consume alcohol?	Yes No	How many drinks per week?
Do you use any recreational drugs?	Yes No	What kind(s)?
What is your dominant hand?	Left Right Ambidextrous	
Are you currently working?	Yes No	Profession:
What is your marital status?		
Do you have any children?	Yes No	How many?
Are you physically active?	Yes No	What activities/sports?

How do you sleep?	Good	Fair	Poor
On average, how many hours of sleep do you get per night?			
How is your diet?	Good	Fair	Poor
What are your stressors?	Work	Commute	Family
Other stressors:			

Review of Systems

Do you currently have, or have you had any of the following in the past year *(select all that apply for each section):*

Constitutional	Hematological	Respiratory	Skin
Vomiting	Adenopathy	Chronic Cough	Discoloration
Chills	Easy Bruising/Bleeding	Shortness of Breath	Bruising
Nausea	DVT	Wheezing	Non Wound Healing
Fever	Anemia	Difficulty Breathing	Rash
Sleep Difficulty			
Fatigue			
None	None	None	None

HEENT	Cardiovascular	Endocrine/Hormonal	Musculoskeletal
Double Vision	Chest Pain	Intolerance of Cold	Decreased ROM
Headaches	Edema	Intolerance of Heat	Joint Redness
Hearing Loss	Palpitations	Weight Loss	Muscle Pain
Hoarseness		Weight Gain	Joint Swelling
Runny Nose		Hair Changes	Muscle Cramps
		Nail Changes	Muscle Weakness
			Leg Cramps
			Joint Stiffness
None	None	None	None

Gastrointestinal	Genitourinary	Neurological	Psychiatric
Abdominal Pain	Bladder Incontinence	Paralysis	Depression
Bowel Habits Change	Urinary Retention	Dizziness	Anxiety
Trouble Swallowing	Irregular Menses	Weakness	Memory Loss
Heartburn/GERD	Non-menstrual Bleeding	Loss of Balance	Substance Abuse
	Pelvic Pain	Numbness	Suicidal Ideas
	Urinary Urgency	Paresthesias	
	Urinary Leakage	Seizures	
	Erectile Dysfunction	Difficulty Walking	
	Decreased Libido		
	Retrograde Ejaculation		
None	None	None	None

Please list any questions/goals you have for this visit:

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DR. JAMES F. WYSS
PATIENT RESPONSIBILITY & COMPLIANCE

UNDERSTANDING YOUR INSURANCE:
Within one insurance company there may be several programs with varying benefits and requirements. It is the patient's responsibility to know and keep up with their program and provisions (In Network deductible, need for referrals to see a specialist, etc.). Please understand your insurance plan's regulations and protocol because unless you follow them carefully, your insurance company may decline all or part of your claim.

PATIENT COMPLIANCE:
Your care is very importance to us. We impress upon our patients the importance of following Dr. Wyss' recommendations and need for follow up visits to ensure quality medical care. If a patient does not follow through with Dr Wyss' treatment plan but continues to seek his advice, we reserve the right to refer you to another physician. We do not charge patients for not showing up to an appointment, however if there are 2 or more no shows, late arrivals or cancellations with less than 24hrs notice, we reserve the right to not offer you a future appointment.

"I understand that as the patient, it is my responsibility to understand my Insurance Plan and Dr Wyss' protocol.

I authorize the release of Dr. James Wyss' records to referring physicians, and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

It is understood and agreed that my purpose in requesting examination and treatment is for medical purposes only and not in connection with pending or proposed litigation and/or a Worker's Compensation case. Should such a situation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation or fill out / sign forms relating to litigation or disability, except to provide a true and accurate copy of any medical records in the possession and control of this office pursuant to an authorization by the undersigned."

Patient Name: _____

Patient Signature: _____ Date: _____

429 E. 75th Street, 4th Fl.. • New York, NY • Tel: 212-606-1731

James Wyss, MD

PHYSICIAN DISCLOSURE FORM
JAMES F. WYSS , MD
HOSPITAL FOR SPECIAL SURGERY
Telephone: 212-606-1731

I. Insurance Status:

Patient Insurance Plan_____

___Participating ___Non-Participating

*A complete list of insurances with which I participate is available at www.hss.edu/physicians

II. I am affiliated with **Hospital for Special Surgery**.

III. During your procedure and/or hospital stay, we may request consultations by physicians who will also follow your case. These doctors will bill you separately.

IV. We recommend that you call each provider listed to confirm their participation status with your insurance company.

Below is a list of providers who may provide services as part of your prescribed treatment. Their contact information is also included

Name	Address	Telephone #
HSS Special Procedures Unit*	429 E. 75th St / 333 Earle Ovington Blvd	212-606-1207
HSS Radiology*	429 E. 75th St / 333 Earle Ovington Blvd	212-774-2607
HSS Pathology*	535 East 70th Street NYC	212-774-2607

***Anesthesia, Radiology and Pathology participate in the same insurance plans as Hospital for Special Surgery. You can find a list of participating plans at www.hss.edu/insurance.**

V. Estimated charges for out of network service are available upon request.

VI. I have been informed of the insurance participation status of James F. Wyss, MD. I have reviewed the information provided to me and understand that the above providers may be involved in my care. I understand that it is my responsibility to contact each provider to determine participation status with my health plan.

Patient Name Signature Date