PATIENT HISTORY FORM

NAME: **UNIT #:**

DATE OF BIRTH: **AGE:** **WHO REFERRED YOU TO OUR OFFICE:**

SHOULDER HISTORY

DATE OF INJURY:

WHICH SHOULDER: right ☐ left ☐ both ☐

PLEASE DESCRIBE YOUR SHOULDER PROBLEM:

WHAT PREVIOUS TREATMENT HAVE YOU RECEIVED FOR THIS CONDITION?:

WORK STATUS

OCCUPATION: **IS THIS A WORK RELATED INJURY?:** yes ☐ no ☐

CURRENT WORK STATUS: full ☐ modified ☐ out of work ☐

IS THERE CURRENTLY ANY LITIGATION PENDING?: yes ☐ no ☐

MEDICAL HISTORY

HEIGHT: ft Inches **WEIGHT (LBS):**

LIST ALL MEDICAL CONDITIONS:

LIST ALL PREVIOUS SURGERIES:

LIST ALL MEDICATIONS & DOSAGES:

LIST ALL MEDICATION ALLERGIES & REACTIONS:

ANY PROBLEMS WITH ANESTHESIA: yes ☐ no ☐

FAMILY HISTORY

DO ANY ILLNESSES RUN IN YOUR FAMILY?:

MOTHER'S AGE: alive ◯ deceased ◯ **MEDICAL PROBLEMS:**

FATHER'S AGE: alive ◯ deceased ◯ **MEDICAL PROBLEMS:**

SOCIAL HISTORY

SMOKING (check):

☐ **current** ☐ packs per day for ☐ years

☐ **quit ->** year quit: ☐

☐ **never**

ALCOHOL (check):

☐ **current:** daily ☐ weekly ☐ less often ☐

☐ **quit ->** year quit: ☐

☐ **never**

HAVE YOU EVER BEEN EXPOSED TO HEPATATIS OR AIDS?: yes ☐ no ☐

REVIEW OF SYSTEMS

Check all that apply to your health

Constitutional
- ❑ Fever, Chills, Sweats
- ❑ Weight loss
- ❑ Change in appetite
- ❑ Excessive fatigue

Respiratory
- ❑ Date of last chest x-ray? _____
- ❑ Sleep apnea
- ❑ Asthma, wheezing
- ❑ COPD
- ❑ Chronic cough
- ❑ Blood in sputum
- ❑ Lung cancer
- ❑ Pneumonia or bronchitis

Musculoskeletal
- ❑ Swelling in multiple joints
- ❑ Excessive flexibility of joints
- ❑ Broken bones? _____
- ❑ Dislocated joints? _____
- ❑ Fibromyalgia
- ❑ Reflex sympathetic dystrophy

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Claustrophobia

Hematologic/Immunology
- ❑ Easy bleeding/bruising
- ❑ Blood transfusions
- ❑ Decreased resistance to infection

Eyes, Ears, Nose, & Throat
- ❑ Recent changes in vision
- ❑ Glaucoma
- ❑ Metal fragments in eyes
- ❑ Nosebleeds
- ❑ Hearing loss
- ❑ Poor balance

Gastrointestinal
- ❑ Ulcers or gastritis
- ❑ Nausea or vomiting
- ❑ Jaundice or liver problem
- ❑ Gallbladder problem
- ❑ GERD/heartburn
- ❑ Blood in stool
- ❑ Colon cancer

Skin
- ❑ Chronic rashes
- ❑ Eczema or Psoriasis
- ❑ Skin cancer
- ❑ Breast lump/nipple discharge

Endocrine
- ❑ Diabetes
- ❑ Thyroid problems
- ❑ Hormone replacement therapy
- ❑ Taken Prednisone
- ❑ Anemia

Cardiovascular
- ❑ Date of last EKG? _____
- ❑ Chest pain or Angina
- ❑ High blood pressure
- ❑ Heart murmur
- ❑ Irregular pulse
- ❑ Elevated cholesterol
- ❑ Calf pain when walking

Genitourinary
- ❑ Bladder infections
- ❑ Blood in urine
- ❑ Difficulty with urination
- ❑ Kidney stones
- ❑ Prostate problems
- ❑ Abnormal pap smear

Neurological
- ❑ Seizures
- ❑ Leg pain/sciatica
- ❑ Weakness of a limb
- ❑ Numbness of a limb
- ❑ Loss of sensation of a limb
- ❑ Bowel/bladder control loss
- ❑ Stroke
- ❑ Loss of memory

The above information is accurate to the best of my knowledge

Patient Signature: **Date**:

I have reviewed this information with the patient

Clinician Signature _____ Date _____

ORTHOPAEDIC PATIENT REGISTRATION FORM

UNIT #: **SOCIAL SECURITY:**

NAME: **AGE:** **DOB :**

ADDRESS: **HOME #:**

CITY: **STATE :** **ZIP :** **WORK # :**

E-MAIL ADDRESS: **CELL #:**

DATE OF INJURY: **TYPE OF INJURY:** ☐WORK ☐AUTO ☐SPORTS ☐OTHER

PCP: **PHONE #:**

ADDRESS: **CITY :** **STATE:** **ZIP :**

REFFERING MD: **PHONE # :**

ADDRESS: **CITY :** **STATE:** **ZIP :**

PRIMARY INSURANCE: **SECONDARY INSURANCE:**

NAME: **NAME:**

POLICY #: **POLICY #:**

ADDRESS: **ADDRESS:**

PHONE #: **PHONE #:**

SUBSCRIBER IF DIFFERENT FROM PATIENT:

☐ **WORKER'S COMP** ☐ **MOTOR VEHICLE ACCIDENT Insurance** **(Check if applicable)**

INSURANCE COMPANY: **CLAIM OR FILE #:**

ADDRESS: **PHONE #:**

CITY: **STATE :** **ZIP :** **FAX #:**

CONTACT OR AGENT AT COMPANY:

EMPLOYER NAME: **PHONE #:**

EMPLOYER ADDRESS:

RELEASE AND ASSIGNMENT FORM

To My Insurance Carriers:

1. **I authorize the release of any medical information necessary to process my insurance claims.**
2. **I authorize and request payment of medical benefits directly to my physicians.**
3. **I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.**
4. **I agree that a photocopy of this form may be used in lieu of the original.**
5. **I understand that I am responsible for the charges that occur as a result of my medical treatment.**

SIGNATURE : **DATE :**

(Patient or Responsible Party)