Ortho***Neuro***

For every motion in life.

Medical History Form

Patient Name: _____ DOB: _____ Age: _____

Dominant Hand: ☐ R ☐ L Height: _____ Weight: _____

Gender ☐ Male ☐ Female

What body part is involved? (Please mark ONLY ONE on the table below)

Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Wrist ☐ R ☐ L	Hand ☐ R ☐ I	Hip ☐ R ☐ L
Knee ☐ R ☐ L	Ankle ☐ R ☐ L	Foot ☐ R ☐ L	Neck ☐ R ☐ I	Back ☐ R ☐ L

*What test/ scans have you had for this problem? ☐ X-Ray ☐ MRI ☐ CATscan ☐ Bone Scan ☐ Nerve Test

Where? _____

In this section, check the ONE BOX that describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ NO INJURY (or onset was) ☐ Gradual ☐ Sudden

How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years

Please indicate why you think it started.

☐ INJURY ☐ Accident ☐ Sport (NOT Auto or Work)

Date: _____ Please specify where and how it happened.

What Sport? _____ School? _____

☐ INJURY AT WORK Date: _____

From a: ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach

☐ WORK RELATED (BUT NO INJURY)

Date: _____ How did your job cause the problem?

☐ AUTO ACCIDENT

Date: How was your car hit?

Comments: _____

On a scale of 0-10 (10 is the worst) how severe is your pain? (Circle) 0 1 2 3 4 5 6 8 9 10

What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent).

Does your pain wake you from your sleep? ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Locking/Catching ☐ Giving Away ☐ Loss of control of bowel or bladder

Since my problem started it is: ☐ Better ☐ Worse ☐ Unchanged

Which make your symptoms better? ☐ Rest ☐ Elevation ☐ Ice ☐ Other

Which makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed ☐ Sitting ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sneezing ☐ Coughing

Were you seen in the E.R for this problem? ☐ Y ☐ N Which E.R? _____ Date: _____

Have you had any of these treatments? Injection: ☐ Y ☐ N Physical Therapy: ☐ Y ☐ N

Brace/Cast: ☐ Y ☐ N

Have you already had surgery for a problem in this same area either recently or in the past? ☐ Y ☐ N

Procedure
#1 _____ Surgeon: _____ City: _____ Date: _____

Procedure
#2 _____ Surgeon: _____ City: _____ Date: _____

Have you had a prior problem with this orthopedic condition in the past? ☐ Y ☐ N (explain below)

_____

Do your other joints have: ☐ Morning stiffness lasting over 30 minutes. ☐ Joint pain or swelling ☐ Gout
☐ Back pain ☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ Prior fracture (which bone?) _____
☐ None of these

Current work status? ☐ Regular ☐ Light Duty (how long?) _____
☐ Not working due to this problem. ☐ Disabled ☐ Retired ☐ Student

When is the last date you worked your regular job? _____

REVIEW OF SYSTEMS

Have you had any of these symptoms? If no, mark None.						NONE	Details/Comments
1)GI	☐ Heartburn, ulcers	☐ Nausea, vomiting	☐ Blood in stool			☐	
	☐ Hepatitis	☐ Liver Disease					
2)ENDO	☐ Thyroid Disease	☐ Heat/Cold Intolerance	☐ Diabetes			☐	
3)CON	☐ Weight Loss	☐ Loss of Appetite				☐	
4)EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss			☐	
5)ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing			☐	
6)CV	☐ Chest Pain	☐ Palpitations				☐	
7)RS	☐ Chronic Cough	☐ Shortness of Breath	☐ Kidney Problems			☐	
8)GU	☐ Painful Urination	☐ Blood in Urine				☐	
9)SK	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps	☐ Psoriasis		☐	
10)NEU	☐ Headaches	☐ Dizziness	☐ Seizures			☐	
11)PSY	☐ Depression	☐ Drug/Alcohol Addiction	☐ Sleep Disorder			☐	
12)HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia			☐	
13)ARE YOU HIV POSITIVE?	☐ Y ☐ N						

MEDICATIONS (Prescription, Over the Counter, Herbal, Vitamin Supplements)

ALLERGIES TO MEDICATIONS? ☐ Y ☐ N If yes, please list and describe reaction: _____

_____

_____

_____

What medications are you taking now?

Medication Name	Dosage	Frequency (how often)	Oral, Injection or Topical
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PAST MEDICAL HISTORY

Are you diabetic? ☐ Y ☐ N If yes, treatment: ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

Are you taking or have you ever taken, blood thinners? ☐ Y ☐ N If yes, which ones? _____

Past Hospitalizations: (Not for Surgery) _____ ☐ None

Have you ever had: ☐ Heart Attack (year_____) ☐ High Blood Pressure ☐ Blood Clots (year_____)

☐ Stroke ☐ Heart Failure ☐ Ankle Swelling ☐ Kidney Failure ☐ Cancer (location_____)

☐ Stomach-ache while taking anti-inflammatories? (includes Advil/Aleve)

Which anti-inflammatories have you had a problem with? _____

☐ **I do not have any of the above conditions.**

PAST SURGICAL HISTORY

What operations have you had and when? Please list: _____

Have you or a family member ever had a reaction to anesthesia? ☐ Y ☐ N Explain: _____

FAMILY HISTORY

Have any <u>direct</u> relatives had any of the following disorders? If so, which relative?

☐ Diabetes _____ ☐ High Blood Pressure _____ ☐ Rheumatoid Arthritis _____

☐ Other _____ ☐ Blood Disorder/Blood Clots _____ ☐ None

Do any direct relatives have the same condition you are being seen for today? ☐ Y ☐ N

SOCIAL HISTORY

Do you use tobacco? ☐ Y ☐ N If yes, packs per day: _____ Patient informed of smoking risk? ☐ Y ☐ N

Alcohol use? ☐ Y ☐ N If yes, how often? ☐ Daily ☐ Other_____/week

Marital History: ☐ M ☐ S ☐ D ☐ W **How many people do you live with?** _____

Occupation: _____ **Employer:** _____ ☐ **Student**

If you are a women age 65 or older…

Have you been screened (DXA scan) for osteoporosis since you turned 60 years old? ☐ Y ☐ N

If yes, what was the result of the testing? _____

Have you been prescribed medication to prevent or treat osteoporosis? ☐ Y ☐ N

If yes, what medication are you taking? _____

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

FOR OFFICE USE ONLY

Review #1 _____ Date: _____ Review #2 _____ Date: _____

AUTHORIZATIONS

Section 1: Financial Policy

I have reviewed OrthoNeuro's Financial Policy and Authorizations (collectively, the "Financial Policy"), hereby acknowledge my responsibilities set forth in the Financial Policy, and hereby make the authorizations set forth in the Financial Policy. Please initial: _____

Section 2: Appointment of Personal Representative to Receive Protected Health Information

You may rely upon your spouse, relatives or friends to be involved in your medical care. OrthoNeuro can Disclose your Protected Health Information to these people if you appoint them as your "personal representatives." To appoint an individual as your personal representative, complete this section:

I hereby appoint the following individual as my personal representative:

Name: _____ **Relationship to me:** _____

I hereby authorize OrthoNeuro to Disclose the following Protected Health Information to my personal representative:

☐ All Protected Health Information

OR One or more of these choices:

☐ Times of Appointments
☐ Prescriptions & Ancillary Equipment
☐ Other _____
☐ Test Results
☐ Copies of Medical Records

I may revoke my appointment of a personal representative at any time in writing. I understand that revocation of my appointment will NOT affect any action OrthoNeuro took in reliance on my appointment before it received written notice of my revocation. **Please initial:** _____

Section 3: Receipt of Notice of Privacy Practices

I hereby acknowledge receiving a copy of OrthoNeuro's Notice of Privacy Practices that outlines my privacy rights and explains how OrthoNeuro is permitted to Use and Disclose my Protected Health Information. I should call OrthoNeuro's Privacy Officer at (614) 890-6555 if I have a question or concern about my privacy rights. **Please initial:** _____

Section 4: Patient Information

Race: _____ Ethnicity: _____ Date of Birth: _____

Language: _____ Social Security Number: _____

Emergency Contact: _____ Phone Number: _____

By signing below, I am acknowledging that I have read and understand this form.

Patient Name (please print)	Patient Signature	Date
If applicable, Parent/Guardian Name (Please Print)	If applicable, Parent/Guardian Signature	Date