

OrthoNeuro

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 <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> I	Hip <input type="checkbox"/> R <input type="checkbox"/> L
Knee <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L	Neck <input type="checkbox"/> R <input type="checkbox"/> I	Back <input type="checkbox"/> R <input type="checkbox"/> L

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

Where? _____ Nerve Test

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	<input type="checkbox"/> Heartburn, ulcers	<input type="checkbox"/> Nausea, vomiting	<input type="checkbox"/> Blood in stool	<input type="checkbox"/>	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease			
2)ENDO	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Heat/Cold Intolerance	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	
3)CON	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite		<input type="checkbox"/>	
4)EYE	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss	<input type="checkbox"/>	
5)ENT	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/>	
6)CV	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations		<input type="checkbox"/>	
7)RS	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/>	
8)GU	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine		<input type="checkbox"/>	
9)SK	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis:	<input type="checkbox"/>	
10)NEU	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures	<input type="checkbox"/>	
11)PSY	<input type="checkbox"/> Depression	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/>	
12)HEM	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Anemia	<input type="checkbox"/>	
13)ARE YOU HIV POSITIVE?		<input type="checkbox"/> Y <input type="checkbox"/> 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 direct 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: _____

OrthoNeuro

Podiatry and Wound Care

PODIATRY HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints)

Have you ever been to a Podiatrist before? YES NO

If YES, please list: Name _____ Last Visit: _____

Date of last visit with Primary Care Physician: _____

Other Physicians and Specialists (eye doctor, endocrinologist, etc.) _____

Athletic Activities in which you participate (please list and indicate frequency) _____

Indicate which foot problems you now have or have had in the past:

	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<u>Notes</u>
Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Athlete's Foot	<input type="checkbox"/>	<input type="checkbox"/>	
Bunions	<input type="checkbox"/>	<input type="checkbox"/>	
Hammertoes	<input type="checkbox"/>	<input type="checkbox"/>	
Corns and Calluses	<input type="checkbox"/>	<input type="checkbox"/>	
Cramps or Numbness in Feet or Legs	<input type="checkbox"/>	<input type="checkbox"/>	
Flat Feet	<input type="checkbox"/>	<input type="checkbox"/>	
Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	
Heel Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Ingrown Toenails	<input type="checkbox"/>	<input type="checkbox"/>	
Plantar Warts	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling in Ankles or Feet	<input type="checkbox"/>	<input type="checkbox"/>	
Wound Healing Problems	<input type="checkbox"/>	<input type="checkbox"/>	

WOUND CARE HISTORY (If applicable)

Where is/are the wound(s) that you are seeking treatment for? _____

How did you get this wound(s)? _____

How long have you had this/these wound(s)? _____

Do you have wound pain? Yes No Pain level _____ (0 being no pain and 10 being the worst)

Who is doing your wound care? _____

What physician(s) have you seen for your wound(s)? _____

What have you or your physician done to treat this/these wound(s)? _____

Patient Signature

Date

Physician Signature

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

Test Results

Prescriptions & Ancillary Equipment

Copies of Medical Records

Other _____

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