ANDREWS INSTITUTE
ORTHOPAEDICS & SPORTS MEDICINE
An Affiliate of Baptist Health Care

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We are happy to schedule you as a new patient with one of our physicians.

In anticipation of your upcoming appointment, we would appreciate your attention to the following information:

- Please complete the enclosed paperwork in its entirety to ensure the most accurate records for our physicians. This includes an up-to-date medication list.
- Please arrive at least 30 minutes early so that we may verify your insurance, scan your cards, and have you ready to see the provider at your appointment time. Please make travel arrangements to be *early* to your appointment.
- If you are late to your appointment, we reserve the right to reschedule your appointment. This policy helps ensure a timely schedule for both the physician and our patients.
- It is the patient's responsibility to verify that the physician you are seeing is in-network with the insurance plan you have. You can call the customer service number located on the back of your card to verify this.
- If you are to be treated for injuries sustained during a motor vehicle accident, please bring your automobile insurance card as well as your health insurance cards.
- Please provide our office with any pertinent medical records, X-ray, MRI, or CT reports. This is immensely helpful to the productivity of your appointment. If the imaging was done outside of the Baptist Health Care System, please bring a CD with images that we can view at your appointment.
- Please keep in mind that our office does not take over prescribing controlled substances (i.e. opioids or narcotics).
- Please **DO NOT** mail your paperwork back to us, bring the completed paperwork with you to the appointment.

We look forward to meeting you at your upcoming appointment. Thank you for choosing Andrews Institute Physical Medicine and Rehabilitation.

APPOINTMENT DATE: ___/___/___ TIME: __:___AM/PM

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Rm#:

BP: _____ HR: _____ R: _____

Ht: _____ Wt: _____

NEW PATIENT HISTORY AND PHYSICAL FORM
Dr. Adam Mullan, Dr. Huaiyu Tan, Dr. Marisa Terry

Patient's Name: _____ Date of Birth: ____/____/____ Age: ____

Body part being seen for: _____ Side of Body (circle): Right Left Both

Date symptoms began: _____ Was there an *injury*? (check) ☐Yes ☐No
If so, how did it happen?: _____

Does the pain *spread/radiate* anywhere (ex. arms, legs)? _____

Associated symptoms (ex. Numbness/tingling or muscle weakness)? _____

How *severe* is the pain: zero being no pain and 10 being the worst pain imaginable?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Quality: What does the pain feel like? ☐Constant - or - ☐ Intermittent
☐Aching ☐Burning ☐Sharp ☐Stabbing ☐Pressure ☐Other: _____

What makes the pain *worse*? _____
What makes the pain *better*? _____

Have you had any of the following symptoms (circle):
Fall within the past month
Bowel/Bladder Incontinence or Severe Constipation
Lack of sensation in the saddle region
Fever, Night sweats, or severe chills

Does the pain affect your enjoyment of life (please explain): _____
Does the pain limit your general activity level (please explain): _____

Current or Prior Pain Treatment/Therapies (please state if helpful or not helpful):
☐Heating pad or hot tub
☐Ice pack
☐Braces
☐Chiropractic Care: _____
☐Acupuncture or Massage
☐Physical Therapy: _____
☐Medication(s): _____
☐Injection(s) / Procedure (s): _____

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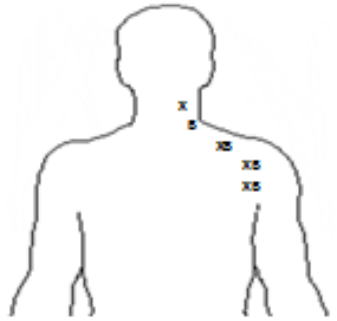
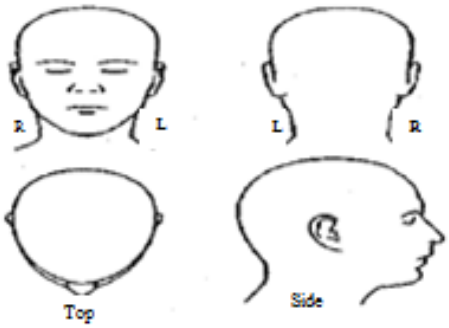
Please use the following symbols to indicate the type and location of your pain on the drawings below.

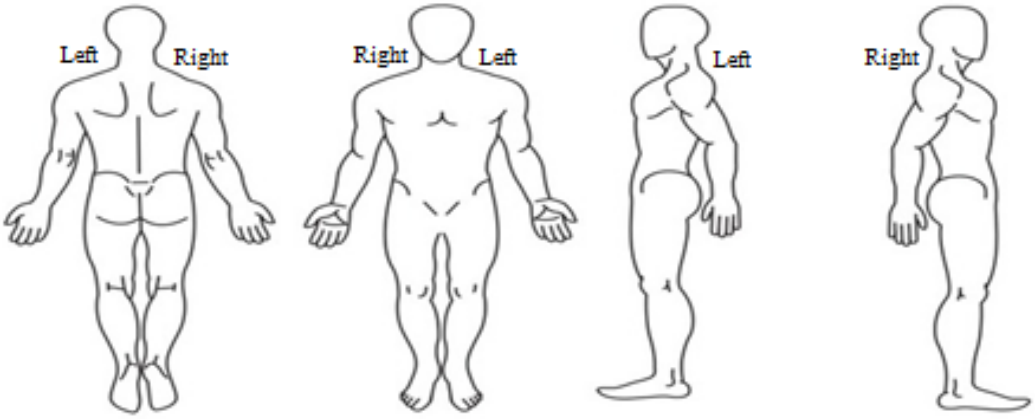
TYPE OF PAIN	SYMBOL
Sharp	X
Shooting	→
Burning	B
Aching	A
Spasming	S
Tingling	T
Numbness	N

EXAMPLE:
Types of pain:
Sharp and burning

Location of pain:
back of neck down
to right shoulder blade







GENERAL MEDICAL INFORMATION

Who is your primary care doctor?_____ Date of last visit: _____

Do you take a blood thinning medication (check): ☐ Yes, name: _____ ☐No

Are you pregnant or attempting to get pregnant? ☐Yes ☐No

List **ALL** current medications (Including vitamins and supplements):

Name:	Dosage:	How Often:	Name:	Dosage:	How Often:
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Preferred Pharmacy (Name and location): _____

ALLERGIES

List medications and food allergies and type of reaction:

_____

_____

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PAST MEDICAL HISTORY

CHECK ANY PROBLEM YOU HAVE BEEN TREATED FOR AND THE DATE OF TREATMENT

☐Arthritis
☐Lupus
☐Rheumatoid Arthritis
☐Osteoporosis
☐Brittle bones
☐Ruptured disc
☐Sciatica
☐Diabetes
☐Stomach ulcers
☐Hypertension
☐Heart attack
☐Heart failure
☐Heart murmur
☐Irregular heartbeat
☐Peripheral vascular disease
☐ Stroke
☐Blood clot
☐Varicose veins
☐Kidney disease
☐Bladder infections
☐Thyroid problems
☐Sickle cell anemia
☐Hepatitis A/B/C
☐Cirrhosis
☐Gallstones
☐HIV/AIDS
☐Tuberculosis
☐Polio
☐Venereal disease
☐Asthma
☐Emphysema
☐COPD
☐GERD
☐Cancer: Type: _____
☐Hereditary defects
☐Glaucoma
☐Depression
☐Drug dependence/ Alcoholism
☐Head injury
☐Convulsion/Seizures
☐Fainting spells
☐Insomnia
☐Gout
☐High Cholesterol/ Triglycerides

PAST SURGERY AND MAJOR ILLNESS/HOSPITALIZATIONS

TYPE OF SURGERY/ILLESS:	DATE OF SURGERY/ILLESS:

SOCIAL HISTORY

Marital Status: ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED ☐SEPARATED

OCCUPATION: _____ Are you working now? ☐YES ☐NO
If not working, when did you last work? _____

Place of Birth: _____School Grade completed: _____

I live in a: ☐House ☐Apartment ☐Condominium ☐Other _____

My Home is a: ☐Single level ☐Multi-Level

I live: ☐Alone ☐With spouse ☐With parent ☐With children ☐Other: _____

Current **Alcohol** Use: ☐Yes (_____ # drinks per day/ week) ☐None ☐ Quit (how long ago: _____)

Current **Tobacco** Use: ☐Yes (_____ # times per day and for ____ years) ☐None ☐ Quit (how long ago: _____)

Current **Caffiene** Use: ☐Yes (____ # drinks per day) ☐None

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FAMILY HISTORY

Mother living: Yes☐ (Age: _____) No☐ (cause of death and age at death:_____)

Father living: Yes☐ (Age: _____) No☐ (cause of death and age at death:_____)

Please check all boxes that apply OR ☐ No significant family history is known

Diagnosis	Mother	Father	Paternal Grandparent	Maternal Grandparent	Siblings	Children
CANCER (Type)						
HEART DISEASE						
HYPERTENSION						
DIABETES						
RHEUMATOID ARTHRITIS						
OSTEOARTHRITIS						
SEIZURES						
KIDNEY DISEASE						
FIBROMYALGIA						
STOMACH ULCERS						
MENTAL ILLNESS						
STROKE						
REACTION TO ANESTHESIA						

PLEASE LIST OTHER PERTINENT INFORMATION YOUR PHYSICIAN SHOULD KNOW:

_____

_____

I hereby attest that I personally completed this form and all the information is true and correct:

_____ _____

Signature of Patient or Guardian completed form: **Date:**

HISTORY FORM REVIEWED BY:_____Date:_____

Physician's or Physician Assistant's Signature

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Review Of Systems Report

Patient Name: _____ Date of Birth: _____

Please look at the following symptoms and mark any issues you have had ***within the last month:***

Constitutional
[ ] Anorexia (no appetite)
[ ] Chills
[ ] Fever
[ ] Malaise (Fatigue)
[ ] Weight loss
[ ] _____

Mouth / Throat / Teeth
[ ] Gum bleeding
[ ] Hoarseness
[ ] Lesions (mouth sores)
[ ] Toothache
[ ] Tooth caries (cavity)
[ ] Tooth trauma
[ ] Throat pain
[ ] Dentures

Gastrointestinal
[ ] Abdominal pain
[ ] Constipation
[ ] Diarrhea
[ ] Nausea
[ ] Melena (dark stool)
[ ] Stool incontinence
[ ] Vomiting

Neurological
[ ] Dizziness
[ ] Headache
[ ] Loss of function
[ ] Lower extremity (legs or feet) numbness
[ ] Memory impairment
[ ] Neck stiffness
[ ] Sensory deficits (less feeling / numbness)
[ ] Tremors
[ ] Upper extremity (arms or hands) numbness
[ ] Vertigo (dizziness)
[ ] _____

Eye
[ ] Absent lacrimation (dry eyes)
[ ] Itching
[ ] Lacrimation (watery eyes)
[ ] Lid swelling
[ ] Pain
[ ] Photophobia (light sensitivity)
[ ] Redness
[ ] Vision changes

Neck
[ ] Lumps
[ ] Pain
[ ] Stiffness
[ ] Swollen glands

Genitourinary
[ ] Dysuria (painful urination)
[ ] Frequency (too often)
[ ] Hematuria (bloody urine)
[ ] Urgency
[ ] Urine output decreased

Psychiatric
[ ] Anxiety
[ ] Depression
[ ] Insomnia
[ ] Psychiatric disorder
[ ] _____

Allergic / Immunologic
[ ] Dermatitis
[ ] Environment allergies
[ ] Food allergies
[ ] Hay fever
[ ] HIV
[ ] Immunologic disorder
[ ] Latex allergy
[ ] _____

Ear
[ ] Discharge
[ ] Hearing loss
[ ] Pain
[ ] Tinnitus (ringing in the ear)

Cardiovascular / Heart
[ ] Bradycardia (slow heart beat)
[ ] Chest pain
[ ] Edema (swelling)
[ ] Irregular rhythm
[ ] Orthopnea (shortness of breath laying down)
[ ] Palpitation (fluttering, pounding, or skip a beat)
[ ] Tachycardia (fast heart beat)
[ ] _____

****Musculoskeletal****
[ ] Back pain
[ ] Gout
[ ] Joint pain
[ ] Neck pain
[ ] Pain
[ ] Sensory deficits (less feeling / numbness)
[ ] Stiffness
[ ] Swelling
[ ] Weakness
[ ] _____

Endocrine
[ ] Cold / heat tolerance
[ ] Diabetes
[ ] Hot flashes
[ ] Polydipsia (excessive thirst)
[ ] Polyuria (frequent urination)
[ ] Thyroid trouble

Nose
[ ] Congestion
[ ] Discharge
[ ] Nose bleeds
[ ] Sneezing

Respiratory / Breathing
[ ] Cough
[ ] Dyspnea (shortness of breath)
[ ] Hemoptysis (coughing up blood)
[ ] Stridor (whistling)
[ ] Wheezing
[ ] _____

Integumentary / Skin
[ ] Abrasions (scrapes)
[ ] Hives
[ ] Jaundice (yellow skin)
[ ] Lesions (cuts)
[ ] Pruritus (chronic itchy skin)
[ ] Rash
[ ] Thin skin
[ ] _____

Heme/Lymph
[ ] Anemia
[ ] Easy bleeding
[ ] Easy bruising
[ ] Night sweats
[ ] Past transfusion
[ ] Swollen lymph nodes
[ ] Transfusion reaction
[ ] _____

*****ANY HISTORY OF:*****

MRSA	[ ] Y [ ] N
Sleep Apnea	[ ] Y [ ] N
Blood Clot	[ ] Y [ ] N
Latex Allergy	[ ] Y [ ] N

_____ _____
Patient Signature Date

PROMIS–29 Profile v1.0

Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
1	Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
2	Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
3	Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
4	Are you able to run errands and shop?	☐	☐	☐	☐	☐
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5	I felt fearful	☐	☐	☐	☐	☐
6	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
7	My worries overwhelmed me	☐	☐	☐	☐	☐
8	I felt uneasy	☐	☐	☐	☐	☐
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9	I felt worthless	☐	☐	☐	☐	☐
10	I felt helpless	☐	☐	☐	☐	☐
11	I felt depressed	☐	☐	☐	☐	☐
12	I felt hopeless	☐	☐	☐	☐	☐
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
13	I feel fatigued	☐	☐	☐	☐	☐
14	I have trouble starting things because I am tired	☐	☐	☐	☐	☐
	In the past 7 days…					
15	How run-down did you feel on average?	☐	☐	☐	☐	☐
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
16	How fatigued were you on average?	☐	☐	☐	☐	☐

PROMIS–29 Profile v1.0

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
17	My sleep quality was.....	☐	☐	☐	☐	☐

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
18	My sleep was refreshing.....	☐	☐	☐	☐	☐
19	I had a problem with my sleep	☐	☐	☐	☐	☐
20	I had difficulty falling asleep	☐	☐	☐	☐	☐

Satisfaction with Social Role

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
21	I am satisfied with how much work I can do (include work at home)	☐	☐	☐	☐	☐
22	I am satisfied with my ability to work (include work at home)……	☐	☐	☐	☐	☐
23	I am satisfied with my ability to do regular personal and household responsibilities	☐	☐	☐	☐	☐
24	I am satisfied with my ability to perform my daily routines.....	☐	☐	☐	☐	☐

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
25	How much did pain interfere with your day to day activities?.....	☐	☐	☐	☐	☐
26	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
27	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
28	How much did pain interfere with your household chores?	☐	☐	☐	☐	☐

Pain Intensity

In the past 7 days…

29	How would you rate your pain on average?.....	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst imaginable pain**

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Patient Demographics:

Patient Name: _____ _____
First MI Last Preferred Name

SSN#: _____ Birth Date: _____ Sex: Male Female

Address: _____ _____ _____ _____
Street Address City State Zip Code

Home #: _____ Cell #:_____ Work #: _____

Marital Status: Married Single Divorced Widowed
Race: African American Asian White Hispanic Other
Ethnicity: Hispanic or Latino Non-Hispanic or Latino
Email Address: _____

How were you referred to our practice? (Circle)
Friend/Relative: _____ Physician Newspaper Radio Healthsource

Guardian Information: (If Patient is a Minor)
Name: _____ Relationship to Patient: _____
SSN#: _____ Birth date: _____ Sex: Male Female
Address: _____ _____ _____ _____
Street Address City State Zip Code

Home #: _____ Cell #:_____ Work #: _____

Payment Information:
Form of Payment: Health Insurance Auto Insurance Worker's Compensation Self Pay

Primary Insurance
Primary Insurance Company: _____ Insured's Name _____
Policy #: _____ Group #: _____ Insured's Date of Birth: _____
Secondary Insurance
Secondary Insurance Company: _____ Insured's Name _____
Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Self-Pay Agreement
I agree to pay for medical services rendered at Andrews Orthopedic and Sports Medicine facilities. I understand that there are payment plans available at my request.
X _____ Date: _____
Release of Information: I authorize Andrews Orthopedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third- party payers in order to assist in the payment of claims.
X _____ Date: _____

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Disclosure to Release Information to Families/ Emergency Contacts and Physicians

I authorize Baptist Physicians Group to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick up prescriptions and/or forms, etc., on my behalf. A photo ID is required for any pick up. These individuals will be considered my emergency contacts. Without authorization, no information may be shared.

Important Note: If you may want or need any healthcare information or scheduling information released to any individuals they need to be specifically listed below. This includes individuals such as: a parent or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches etc.

I authorize Baptist Physicians Group and his staff to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Consent to Treatment

I hereby grant authorization and consent for medical treatment and /or procedures for myself or for the patient for whom I am the parent or legally authorized guardian, and I understand that no guarantees or assurance has been made as to the results for which may be obtained.

_____
Patient or Guardian Initials

Photo Documentation

I hereby grant authorization for the office staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture as additional protection against the theft of my medical identity. I further grant authorization for the office staff to take photo identification of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

_____
Patient or Guardian Initials

Notice of Privacy Practices

I have reviewed a copy of the Baptist Health Care "Notice of Privacy Practices" and understand that a copy is available upon request, I agree with these privacy policies.

_____
Patient or Guardian Initials

Insurance Assignment and Financial Responsibility

I hereby authorize Baptist Physicians Group to release any medical information required during the course of examination and treatment to my insurance company and/or third-party payers in order to assist in the payment of claims. I permit payment to Baptist Physicians Group form my insurance for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible, and non-coverage services. I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay my bill in full for services rendered by Baptist Physicians Group.

_____
Patient or Guardian Initials

Print Name of Patient or Guardian: _____
Relationship to patient: _____
Patient or Guardian Signature: _____ Date: _____