PATIENT DEMOGRAPHICS:

Patient Name: _____ _____
First MI Last Preferred Name

DOB: _____ **Sex:** MALE FEMALE **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____

Marital Status: Married Single Divorced Widowed **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

Race: African-American American-Indian Asian White Hispanic Other:_____

Email Address: _____

GUARDIAN INFORMATION (If patient is a minor):

Name: _____ **Relationship:** _____
First MI Last

DOB: _____ **Sex:** MALE FEMALE **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____

PAYMENT INFORMATION:

Form of Payment: Health Insurance Auto Insurance Workers Comp Self Pay

Primary Insurance
Insurance Company: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Insured's DOB: _____

Secondary Insurance
Insurance Company: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Insured's DOB: _____

Self Pay Agreement: I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine Center. I understand that there may be payment plans available at my request.

X_____ Date: _____

Addition Medical Forms: All medical paperwork including but not limited to, FMLA paperwork, disability forms, and short term-disability paperwork, will be processed in 7-10 business days. Please note this paperwork comes with a onetime service charge of $25.00. Paperwork will not be processed until payment has been received.

TO ALL PATIENTS:

It is the patient's responsibility to obtain previous medical records (MRI reports, surgical reports, office notes, etc.) or diagnostic testing (MRIs, EMG studies, X-ryas, etc. on a **DISK**). These records must be provided at the time of your visit unless otherwise notified.

History of Present Illness

NAME:_____

DOB:_____ **AGE**:_____

Occupation/Job:_____

Height:_____ft **Weight**:_____lbs

Hand Dominance:
Right handed Left handed

Patient type:
NEW PATIENT NEW COMPLAINT

Body Part (Please circle):
SHOULDER KNEE HIP OTHER:_____

Which side (Please circle):
RIGHT LEFT BOTH

SEVERITY
How severe is the pain (0=NONE, 10=SEVERE PAIN)
AT REST:_____ AT WORST:_____

QUALITY
How would you describe the pain (Circle all that apply):
Sharp Dull Aching Throbbing

Other:_____
_____

CONTEXT

How did you injure yourself?:

No Injury- it just started hurting
Motor Vehicle Accident
Worker's Compensation Claim
Sport Injury (which sport):_____

Briefly describe the injury:

_____
_____
_____

TIMING

Is your pain: Constant Intermittent

DURATION

What is the date of injury/onset:_____

How long have you had symptoms:

_____days _____months _____years

MODIFYING FACTORS

What makes the pain better?:

_____
_____
_____

What makes it worse?:

_____
_____
_____

Describes your current limitations:

_____
_____
_____

Associated Symptoms
Circle any signs/symptoms associated with the injury:

SWELLING	STIFFNESS
POPPING	INSTABILITY
GIVING AWAY	NUMBNESS
WEAKNESS	BURNING
CATCHING	OTHER:_____

PREVIOUS EVALUATION/TREATMENT
Diagnosis (If given):_____

Have you had: XRAYS MRI CT Scan

Previous Treatment (PT, injections, bracing, etc.)

_____
_____

Prior surgery on the effected body part:

_____
_____

Interested in surgery if offered? YES NO

(Continue to next page….)

MEDICAL HISTORY

PHARMACY

Name:_____

Location:_____

OTHER PROVIDERS

Referring Physician:_____ Facility:_____

Primary Care Physician:_____ Facility:_____

Cardiologist(if applicable):_____ Facility:_____

Coach/ Athletic Trainer/Team Doctor:_____ School:_____

Contact Number:_____

PAST MEDICAL HISTORY

Please check if you have had any of these medical problems in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Liver disease		
Arthritis			Kidney disease		
Heart Palpitations			Loss of vision		
Asthma			Mitral valve prolapse		
Bleeding Disorder			Neuropathy		
Blood Clots			Paralysis		
Cancer- Type:_____			Peripheral vascular disease		
Chest pain/ Angina			Pneuomonia		
Diabetes- Type:_____			Psychiatric illness		
Delayed Wound Healing			Pulmonary embolism		
Gall bladder disease			Reflux		
Gastric ulcer			Skin ulcer		
Glaucoma			Steroid use (chronic)		
Heart attack			Stroke		
Heart failure			Thyroid disease		
Hepatitis B			Tuberculosis- TB		
Hepatitis C			Urinary infections		
High blood pressure			Valve disorders (heart)		
HIV/AIDS			OTHER (explain):		
Immune deficiency					

(Continue to next page)

MEDICAL HISTORY

Please list any **prior surgeries**/operations you have had:

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any **MEDICATIONS** you are currently taking:

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
1)			7)		
2)			8)		
3)			9)		
4)			10)		
5)			11)		
6)			12)		

ALLERGIES

1. Do you have any ALLERGIES to medications/substances? (please list reaction type: eg hives, sneezing, cough)

   _____

   _____

2. Do you have an allergy to LATEX? YES NO

FAMILY MEDICAL HISTORY (Please list major illnesses that affect your immediate family):

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

SOCIAL HISTORY:

Alcohol Use: (Never) (Yes- Current) (Yes-Former) Drinks per week:_____

Cigarette Use: (Never) (Yes- Current) (Yes-Former) Packs per day:____ Years:_____

Smokeless Tobacco: (Never) (Yes- Current) (Yes-Former)

Illicit Drug Use: (Never) (Yes- Current) (Yes-Former) Type:_____

(Continue to next page)

MEDICAL HISTORY

REVIEW OF SYSTEMS (Please circle any that apply):

1. **GENERAL**

   Weight Loss Chills Fever Malaise/Fatigue None

2. **EYES**

   Vision Change Eyes Crossed Itching Pain None

3. **EARS, NOSE, THROAT**

   Loss of hearing Congestion Ringing in ear Throat pain None

4. **CARDIOVASCULAR**

   Chest pain Edema Irregular rhythm Palpitations None

5. **RESPIRATORY**

   Dyspnea Wheezing Cough None

6. **GASTRONTESTINAL**

   Change in bowel habits Constipation Nausea Abdominal pain None

7. **MUSCULOSKELETAL**

   Stiffness Joint pain Swelling None

8. **SKIN**

   Abrasions Hives Itching Lesions None

9. **NEUROLOGICAL**

   Headaches Loss of consciousness Upper/Lower Extremity Numbness None

10. **PSYCHIATRIC**

    Anxiety Depression Memory Change Mood Swings None

11. **ENDOCRINE**

    Hot/Cold intolerance Diabetes Hot flashes None

12. **HEMATOLOGICAL**

    Anemia Easy Bruising Night Sweats None