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: _____

**Additional 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-rays, etc. on a DISC). These records must be provided at the time of your visit unless otherwise notified.

# HISTORY OF PRESENT ILLNESS

**Name:**_____

**DOB:** _____ **Age:** _____

**Occupation/Job:** _____

**Height:** _____ **Weight:** _____

***LOCATION*** (Please circle):
SHOULDER KNEE HIP OTHER:_____

**Which side** (Please circle):
LEFT RIGHT BOTH

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

***QUALITY***
**How would you describe your pain** (Circle all that apply):
Sharp Dull Aching Throbbing
Other:_____
_____

***CONTEXT***
**How did you injure yourself?:**
No injury – it just started hurting
Sports (Which sport):_____
Motor vehicle accident
Worker's compensation claim
**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 your pain better:**
_____
_____
_____

**What makes it worse:**
_____
_____
_____
_____

**Describe your current limitations:**
_____
_____
_____

***ASSOCIATED SYMPTOMS***
**Circle any signs/symptoms associated with the injury:**

| | |
|---|---|
| SWELLING | STIFFNESS |
| POPPING | INSTABILITY |
| GIVING AWAY | NUMBNESS |
| WEAKNESS | OTHER |
| CATCHING | |

***PREVIOUS EVALUATION/TREATMENT***
**Diagnosis** (If given): _____

**Previous treatment** (injections, PT, bracing, etc.):
_____
_____
_____

**Previous surgery**:
_____
_____
_____

**Have you had:** XRAYS MRI CT SCAN

**Interested in surgery if offered?** YES NO

# HISTORY OF PRESENT ILLNESS

**PHARMACY**

Name: _____

Location: _____

Referring Physician: _____ Facility: _____

Contact Number: _____ Fax: _____

Primary Care Physician: _____ Facility: _____

Contact Number: _____ Fax: _____

Coach/Trainer/Team Doctor: _____ School: _____

Contact Number: _____ Fax: _____

**PLEASE FILL OUT THIS FORM WITH ANY NEW OR UPDATED MEDICAL CONDITIONS**

**Medical History (**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 Arrythmia/Palpitations | | | Loss of Vision | | |
| Asthma | | | Mitral Valve Prolapse | | |
| Bleeding Problems | | | Neuropathy | | |
| Blood Clots | | | Paralysis | | |
| Cancer: Type _____ | | | Peripheral Vascular Disease | | |
| Chest pain/Angina | | | Pneumonia | | |
| Diabetes | | | Psychiatric Illness | | |
| Gall Bladder Disease | | | Pulmonary Embolism | | |
| Gastric Ulcers | | | Reflux | | |
| Glaucoma | | | Skin Ulcer/Breakdown | | |
| Heart Attack | | | Steroid Use | | |
| Heart Failure | | | Stroke | | |
| Heart Murmur | | | Thyroid Disease | | |
| Hepatitis B | | | Tuberculosis – TB | | |
| Hepatitis C | | | Urinary Infections | | |
| High Blood Pressure | | | Valve Disorders (heart) | | |
| HIV/AIDS | | | Wound Healing Problems | | |
| Immune Deficiency | | | OTHER: | | |

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

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

Please list any **Medications** that you are currently taking:

| **MEDICATION** | DOSE | DOCTOR | **MEDICATION** | DOSE | DOCTOR |
|---|---|---|---|---|---|
| 1) | | | 6) | | |
| 2) | | | 7) | | |
| 3) | | | 8) | | |
| 4) | | | 9) | | |
| 5) | | | 10) | | |

Do you have any **allergies** to medications/substances and/or **LATEX**? Yes NO

**Family Medical History** (Please list major illnesses that affect immediate family):

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

**Social History:**

ALCOHOL USE: Yes No Drinks per week: _____

CIGARETTE USE : Yes No Packs per day:_____ Years: _____

SMOKELESS TOBACCO USE: Yes No Years: _____

ILLICIT DRUG USE: Yes No Type: _____

**Review of Systems** (Please circle which applies):

1. **GENERAL**
   Recent weight change Chills Fever Weakness/Fatigue None
   Other:_____
2. **EYES**
   Vision change Glasses/contacts Cataracts Glaucoma None
   Other:_____
3. **EARS, NOSE, THROAT**
   Loss of hearing Ear ache/infections Ringing in ear Hoarseness None
   Other:_____
4. **CARDIOVASCULAR**
   Chest pain Swelling in legs Shortness of breath Palpitations None
   Other: _____
5. **RESPIRATORY**
   Shortness of breath Wheezing/Asthma Frequent Cough None
   Other:_____
6. **GASTRONTESTINAL**
   Heartburn Acid reflux Nausea/vomiting Abdominal pain None
   Other: _____
7. **MUSCULOSKELETAL**
   Arthritis/Joint stiffness Muscle aches Swelling of joints None
   Other: _____
8. **SKIN**
   Rash Ulcers Abnormal scars Sores None
   Other: _____

9. **NEUROLOGICAL**

Headaches Fainting/blackouts Dizziness None

Other: _____

10. **PSYCHIATRIC**

Depression Nervousness Anxiety Mood swings None

Other: _____

11. **ENDOCRINE**

Excessive thirst or hunger Hot/cold intolerance Hot flashes None

Other: _____

12. **HEMATOLOGICAL**

Easy bruising Easy bleeding Anemia None

Other: _____