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….)

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)

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

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 Orthopaedic 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: _____

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 will 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 parents or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches.

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 #: _____