MEDICAL HISTORY FORM

APPOINTMENT DATE: ______________________

NAME: ______________________ DATE OF BIRTH: ______________________

ADDRESS: ______________________

CITY: ______________________ STATE: ________ ZIP: ______________________

AGE: ________ SEX: FEMALE MALE HEIGHT: ________ WEIGHT: ________ DOMINANT HAND: RIGHT LEFT

MARITAL STATUS: ______________________ SOCIAL SECURITY: ______________________

PREFERRED PHONE NUMBER: (______)__________-______________ THIS IS MY ☐ HOME ☐ WORK ☐ MOBILE

OTHER PHONE: (______)__________-______________ EMAIL ADDRESS: ______________________

EMPLOYER: ______________________ OCCUPATION: ______________________

IF STUDENT, COLLEGE OR SCHOOL NAME: ______________________

ADDRESS: ______________________

CITY: ______________________ STATE: ________ ZIP: ______________________

INSURANCE INFORMATION

COMPANY: ______________________ INSURANCE PHONE: (______) ______-__________

ADDRESS: ______________________

CITY: ______________________ STATE: ________ ZIP: ______________________

POLICY NUMBER: ______________________ GROUP NUMBER: ______________________

GUARANTOR OR POLICY HOLDER: ______________________ DATE OF BIRTH: ______________

PHYSICIAN INFORMATION

PRIMARY PHYSICIAN: ______________________

ADDRESS: ______________________

CITY: ______________________

STATE: ______________ ZIP: ______________

PHONE: ______________________

FAX: ______________________

REFERRING PHYSICIAN: ______________________

ADDRESS: ______________________

CITY: ______________________

STATE: ______________ ZIP: ______________

PHONE: ______________________

FAX: ______________________

MEDICAL HISTORY FORM

WHAT BODY PART IS INVOLVED? (Please mark all that apply)

Shoulder: R L Elbow: R L Knee: R L Ankle: R L

Have you experienced: Pain Numbness Weakness Swelling Stiffness

Other: ______________________________

How long ago did it start? ________ Days ________ Weeks ________ Months ________ Years

Have you had a problem like this before? YES NO

In this section, check the **one box** which best 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: (please circle type of onset) GRADUAL SUDDEN

Please indicate why you think it started: ______________________________

INJURY: (please circle) ACCIDENT SPORT ____________ WORK SCHOOL OTHER ____________

Please specify where and how it happened: ______________________________

______________________________ DATE OF INJURY: ____/____/______

ON A SCALE OF 0 – 10 (10 IS THE WORST) HOW SEVERE IS YOUR PAIN? (CIRCLE) 0 1 2 3 4 5 6 7 8 9 10

WHAT IS THE QUALITY OF THE PAIN? Sharp Dull Stabbing Throbbing Aching Burning

THE PAIN IS: Constant Intermittent (comes and goes)

DOES YOUR PAIN WAKE YOU FROM YOUR SLEEP? YES NO

DO YOU HAVE: Swelling Bruises Numbness Tingling Weakness Locking/Catching Giving Way

SINCE MY PROBLEM STARTED, IT IS: Getting Better Getting Worse Unchanged

WHAT MAKES YOUR SYMPTOMS WORSE? Standing Walking Lifting Exercise Twisting Lying In Bed Bending Squatting Kneeling Stairs Sitting

WHICH MAKE YOUR SYMPTOMS BETTER? Rest Elevation Ice Heat Other: ______________

HAVE YOU HAD ANY OF THESE TREATMENTS? Injection Brace Physical Therapy

WHAT TEST/SCANS HAVE YOU HAD FOR THIS PROBLEM? X-Rays MRI CAT Scan Nerve Test (EMG/NCV)

DID YOU BRING YOUR FILMS OR CD ROM? YES NO Report Only______________

Have you already had surgery for a problem in this same area either recently or in the past? YES NO
If yes, please list below:

Procedure #1 ______________________________
Date ____________ Surgeon ______________________________

Procedure #2 ______________________________
Date ____________ Surgeon ______________________________

MEDICAL HISTORY FORM

PLEASE LIST ALL CURRENT MEDICATIONS:

NAME	DOSAGE	FREQUENCY

ALLERGIES TO ANY MEDICATIONS

PENICILLIN YES NO Reaction: ______________________________

SULFA DRUGS YES NO Reaction: ______________________________

NOVOCAINE YES NO Reaction: ______________________________

OPIATES (CODEINE/VICODIN/ PERCOCET) YES NO Reaction: ______________________________

CORTISONE YES NO Reaction: ______________________________

FOOD(S): ____________________ YES NO Reaction: ______________________________

OTHER: ______________________________ Reaction: ______________________________

LATEX ALLERGY SCREENING: Have you ever had a reaction such as swelling, itching or difficulty breathing when exposed to latex, rubber materials like gloves, condoms, balloons or food such as bananas, avocados, papayas, or kiwi fruit? YES NO Reaction: ______________________________

REVIEW OF SYSTEMS HAVE YOU HAD ANY OF THESE SYMPTOMS? IF NO, MARK NONE.

GI	Heartburn, Ulcers	Nausea, Vomiting	Hepatitis or Liver Disease			NONE
ENDO	Thyroid Disease	Heat or Cold Intolerance				NONE
CON	Weight Loss	Loss of Appetite				NONE
EYE	Blurred Vision	Double Vision	Vision Loss			NONE
ENT	Hearing Loss	Hoarseness	Trouble Swallowing			NONE
CV	Hypertension	Palpitations	Pacemaker	Congestive Heart Failure	Heart Disease	NONE
RS	Chronic Cough	Shortness of Breath	Asthma	COPD	Sleep Apnea	NONE
GU	Painful Urination	Blood in Urine	Kidney Problems	Kidney Failure		NONE
SK	Frequent Rashes	Skin Ulcers	Lumps	Psoriasis		NONE
NEU	Headaches	Dizziness	Seizures	Epilepsy	Neurological Disorders	NONE
PS	Depression	Drug/Alcohol	Addiction	Psychological Illness		NONE
HEM	Easy Bleeding	Easy Bruising	Anemia	Thrombosis or Embolisms		NONE

OTHER: ______________________________

Are you pregnant? YES NO Delivery date: ______________________________

DO YOUR <u>OTHER JOINTS</u> HAVE: Morning stiffness lasting over 30 minutes Rheumatoid arthritis Osteoporosis Joint or pain swelling Prior fracture (which bone) ____________________ None of these

PAST MEDICAL HISTORY

Are you Diabetic? YES NO If yes, treatment: Insulin ____________________ Oral Meds Diet NONE

Have you ever had blood clots? YES NO

Are you taking, or have you ever taken, blood thinners? YES NO

If yes, which one? ______________________________

Are you still taking this medication? YES NO

Are you HIV positive? YES NO

Have you ever had a Staph Infection or MRSA? YES NO

MEDICAL HISTORY FORM

PAST NON-ORTHOPEDIC SURGICAL HISTORY: What operations have you had and when? Please list:

____

____

HAVE YOU OR A FAMILY MEMBER EVER HAD A REACTION TO ANESTHESIA? YES NO

If yes, EXPLAIN:____

____

____

Have you ever had:

☐ Heart Attack (year ___________) ☐ Stroke ☐ Ankle Swelling ☐ Cancer (type______________________)

☐ Stomach ache while taking anti-inflammatory medication (includes Advil/Aleve)

What anti-inflammatory medication have you already had a problem with? ______________________

Reaction: ____

☐ I do not have any of the above conditions.

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

Diabetes________________________ High Blood Pressure________________________

Heart Disease________________________ Rheumatoid Arthritis________________________

Cancer ________________________ Neurological or Nerve Disorders ________________________

SOCIAL HISTORY:

Do you use tobacco? YES NO If yes, packs per day_____________

Alcohol use? YES NO If yes, how often? Daily Other _______/ week

Chemical Dependency? YES NO If yes, please specify ______________________________

PLEASE SIGN: The information on these forms is accurate to the best of my knowledge.

____

SIGNATURE DATE

New York Assignment of Benefits

(Aetna, Blue Cross/Blue Shield, Cigna, HIP, Oxford, and United Healthcare)

In consideration of services rendered or to be rendered to the above named patient, I hereby authorize payment of assigned benefits to Dr. Answorth Allen. I also understand that I am responsible for any yearly deductibles and co-insurance payments, in accordance with my insurance plan(s).

____

SIGNATURE DATE