PATIENT DEMOGRAPHICS

PATIENT ID # _____
(Please Leave Blank)

Please Use BLACK INK

NWIA BONE, JOINT & SPORTS SURGEONS, P.C.

PATIENT'S NAME _____
Last First Middle

ADDRESS _____CITY_____STATE_____ZIP_____

TELEPHONE_____ CELL PHONE _____

SOCIAL SECURITY #_____ SEX_____ BIRTHDATE_____ AGE_____

EMPLOYER _____ ADDRESS _____ EMPLOYER PHONE # _____

RACE ☐ Caucasian ☐ Asian ☐ Hispanic/Latino ☐ African American ☐ American Indian ☐ Native Hawaiian

MARITAL STATUS M___ S___ W___ D___ Sep___ E-MAIL ADDRESS: _____

WORK STATUS ☐ Working (☐ Full-Time ☐ Part-Time) ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

GUARANTOR *(If Patient is a Minor)	INSURED SUBSCRIBER INFORMATION *(If not patient)
Name_____	Name_____
Birthdate_____	Birthdate_____
Employer_____	Employer _____
Employer Address _____	Employer Address _____
Full Time or Part Time Employment _____	Full Time or Part Time Employment _____
Telephone (primary)_____	Telephone (primary)_____
Telephone (work)_____	Telephone (work)_____
Social Security #_____	Social Security #_____

NEAREST FRIEND OR RELATIVE WE MAY CONTACT IN CASE OF EMERGENCY

Name_____Relationship_____Phone_____

If you have Health Insurance, please present your card(s) to the front desk, along with your photo ID.

Is this a Worker's Compensation claim? Yes___ No___ Date of Injury_____

Employer_____Address_____

Accident Related? Yes ☐ No ☐ Auto? Yes ☐ No ☐ Other? Yes ☐ No ☐ Date of Accident_____

Personal Physician_____ Referring Physician _____

I do hereby voluntarily consent to permit any associated physician, therapist or assistant of **NWIA Bone, Joint & Sports Surgeons, PC** to perform diagnostic procedures and such medical treatment or procedures as is necessary or advisable in their judgment for my medical care. I authorize **NWIA Bone, Joint, & Sports Surgeons, PC** to release Medical information per HIPAA regulations about me to myself, my insurance company, workman's compensation or other medical provider for continuity of my care. I authorize direct payment of medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to **NWIA Bone, Joint & Sports Surgeons, PC**. I understand that I am fully responsible and guarantee payment of services rendered by anyone in this office. I also permit a copy of this authorization be used in place of the original. This assignment will remain in effect until revoked by me in writing. Discrimination is against the law, **NWIA Bone, Joint & Sports Surgeons, PC** complies with applicable federal civil rights and does not discriminate on the basis of race, color, national origin, age, disability or sex. My signature below also indicates that I have been given an opportunity to read the Notice of Nondiscrimination and Accessibility Requirements for **NIWA Bone, Joint & Sports Surgeons, PC** and have any questions answered before signing.

Patient / Guardian Signature:_____ Date:_____
(Parent signature if patient is under 18)

PATIENT ID #: _____ ***PLEASE USE BLACK INK***

ORTHOPEDIC AND COMPREHENSIVE MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____

AGE:_____ HEIGHT:_____ ft _____ in WEIGHT:_____ lbs

Why are you seeing the doctor today?_____

What started the pain/problem? _____

_____

_____

How long has the pain/problem been present? _____

Has the pain/problem worsened recently? ☐ No ☐ Yes, how recently? _____

Quality of the pain: ☐ Sharp ☐ Burning ☐ Dull ☐ Aching

How severe is the pain at the location described above? ☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

What makes the pain/problem better? _____

What makes the pain/problem worse?_____

Is the pain (*check all that apply*): ☐ Continuous ☐ Activity related ☐ Night pain ☐ Unpredictable

Any Other Symptoms? _____

_____

_____

What other treatments have you tried?

☐ Physical Therapy/Exercise	☐ TENS unit	☐ Narcotic medications	☐ Cast/boot	☐ Braces
☐ Massage/Ultrasound	☐ Traction	☐ Anti-Inflammatories	☐ Orthotics	
☐ Manipulation	☐ Surgery	☐ Steroid injections	☐ Cane/Walker/Crutches	

PERSONAL PHYSICIAN _____ REFERRING PHYSICIAN _____

Previous physicians seen for <u>today's</u> problem: _____

X-Rays and Tests for <u>today's</u> problem:

	Results	Date	Location
☐ X-Rays			
☐ MRI			
☐ CT Scan			
☐ Bone Scan			
☐ Other			

Did this problem start as the result of an Auto Accident? ☐ No ☐ Yes Date of Accident? _____

Did this problem start at work? ☐ No ☐ Yes What day did this start?_____

Have you missed work because of this problem?_____

Name:_____ Date of Birth:_____

PAST MEDICAL HISTORY: Check all that apply ☐ **None Apply**

☐ Heart attack	☐ Asthma	☐ Rheumatoid arthritis	☐ Depression
☐ Heart failure	☐ Tuberculosis	☐ Osteoarthritis	☐ ADHD
☐ Abnormal heartbeat	☐ Emphysema	☐ Gout	☐ Seizures
☐ High blood pressure	☐ Thyroid	☐ Osteoporosis	☐ Migraine
☐ Stroke	☐ Stomach ulcers	☐ Cirrhosis	☐ Cerebral palsy
☐ Blood clots in leg	☐ Gastric reflux	☐ Hepatitis (A, B or C)	☐ Downs syndrome
☐ Blood clots in lung	☐ Hiatal hernia	☐ HIV/AIDS	☐ Spina bifida
☐ Poor circulation	☐ Kidney failure	☐ Bleeding disorder	☐ Neurofibromatosis
☐ High cholesterol	☐ Kidney stones	☐ Anemia	☐ MRSA
☐ Neuropathy: ☐ Hands or ☐ Feet		☐ Blood Antibody	

☐ Cancer: _____(type/treatment)

☐ Diabetes: Year diagnosed _____Currently controlled with ☐ insulin ☐ oral medications ☐ diet

☐ Other: _____

Have you ever had a BONE MINERAL DENSITY TEST? ☐ No ☐ Yes

If Yes, When_____Where_____

FAMILY HISTORY: Check all that apply ☐ **None apply**

☐ Heart problems	☐ Diabetes	☐ Arthritis	☐ Bleeding problems
☐ Seizure	☐ Cancer	☐ High Blood Pressure	☐ Stroke
☐ Gout	☐ Kidney problems	☐ Lung problems	☐ Mental Illness
☐ Alcoholism	☐ Blood clots (legs or lungs)	☐ Other:_____	

REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?)

☐ Fever	☐ Sleep apnea (snoring)	☐ Nausea	☐ Chills	☐ Hoarseness
☐ Weight loss	☐ Cough	☐ Diarrhea	☐ Weight gain	☐ Trouble swallowing
☐ Constipation	☐ Vision changes	☐ Chest pain	☐ Hemorrhoids	☐ Glasses/Contacts
☐ Palpitations	☐ Stomach pain	☐ Hearing loss	☐ Swollen ankles	☐ Urinary difficulty
☐ Dizziness	☐ Shortness of breath	☐ Anxiety	☐ Ear pain	☐ Seasonal allergies
☐ Hyperactivity	☐ Nosebleeds	☐ Skin rashes	☐ Memory loss	☐ Toothache
☐ Swollen glands	☐ Blackouts	☐ Gum problems	☐ Poor appetite	☐ Headache
☐ Vomiting	☐ Other: _____			

☐ ***I have not experienced any of the above symptoms in the last 30 days.***

SOCIAL HISTORY:

Work status: ☐ Working ☐ Unemployed ☐ Disabled ☐ On leave ☐ Retired ☐ Student

Occupation_____ ☐ Full-Time ☐ Part-Time

Dominant Hand ☐ Right ☐ Left

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Children ☐ No ☐ Yes, How Many?_____

Do you live alone?_____ If no, who lives with you?_____

Are you currently smoking?_____ If yes, how many packs a day?_____ For how many years?_____

Have you quit smoking? If so, when did you quit?_____ How many years did you smoke?_____

How many packs a day did you previously smoke?_____Other forms of tobacco?_____

Alcohol Use ☐ Never ☐ Social ☐ Frequently (more than twice a week) ☐ Alcoholic ☐ Recovering Alcoholic

Illegal Drug Use ☐ Never ☐ In the past ☐ Currently Types of Drugs_____

Name:_____ Date of Birth:_____

PHARMACY _____

MEDICATIONS (prescribed and over the counter):

☐ ***I take no medications***

☐ ***Please see attached list***

Name of Medication	Dose	Reason

ALLERGIES TO MEDICATIONS: ☐ **No Allergies**

Name of Medication	Reaction (rash, swelling, stomach upset, etc.)

LATEX ALLERGY: ☐ No ☐ Yes

METAL ALLERGIES: ☐ **No Allergies** ☐ Yes_____ (List Metals)

PAST SURGICAL HISTORY: ☐ **No Prior Surgery**

Operation	Date	Surgeon/Hospital

Have you ever had a Blood Transfusion? ☐ No ☐ Yes If yes, Date: _____
Have you ever had general anesthesia? ☐ No ☐ Yes
If YES, have you had any problems related to this? ☐ No ☐ Yes
Please explain any problems related to general anesthesia: _____

I have read and confirmed the above information with the patient:

NWIABJSS Physician Signature:_____ Date:_____

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