MEDICAL HISTORY FORM

Date

PATIENT INFORMATION

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

Age **Date of Birth** **Right or left handed?** ◯ Right ◯ Left

Working Status ◯ Working ◯ Retired ◯ Disabled

Occupation

PHYSICIANS

Referring Physician *(First) (Last)* **Telephone**

Primary Care Physician *(First) (Last)* **Telephone**

MEDICAL INFORMATION

Chief Complaint *(Example: Right hip pain)*

Date of injury or onset of symptoms

Describe your symptoms *(Example: a sharp pain when I walk)*

How did the injury happen?

Symptom Relief *(Example: rest, heat/cold, therapy, medication)*

Symptom Aggravation *(Example: activity, movement)*

Additional Symptoms

Describe Treatment

Have you had any diagnostic tests for this problem? ◯ Yes ◯ No **If yes, what & where?**

Has a physician recommended that you have surgery for this problem? ◯ Yes ◯ No

Name of previous treating physician(s), if any?

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY *(Please list the surgical procedure, date of procedure and any complications, if applicable)*

Have you ever had problems with anesthesia? ◯ Yes ◯ No

If yes, please describe:

Patient Name_____

SOCIAL HISTORY

Student? ◯ Yes ◯ No

School _____ **Grade** _____

Sport _____

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Do you live alone? ◯ Yes ◯ No

Alcohol use ◯ Never ◯ Occasional ◯ Daily ◯ Heavy

History of alcoholism? ◯ Yes ◯ No

History of drug use? ◯ Yes ◯ No

FAMILY HISTORY

MEDICATIONS *(Prescription, nonprescription, herbal supplements, vitamins, other)*

Medication Name	Dosage	Medication Name	Dosage

Are you taking low-dose aspirin? ◯ Yes ◯ No

Are you taking anti-coagulants? ◯ Yes ◯ No

Are you taking corticosteroids? ◯ Yes ◯ No

Have you taken at least two different anti-inflammatory medications for your condition? ◯ Yes ◯ No

If yes, for how long? _____

Have you ever had a DEXA scan (bone density test)? Yes No

ALLERGIES (*Please list type of allergy (medications, latex, metals, etc) and type of reaction you experience)*

RISK FACTORS

Tobacco use ◯ Never Smoked ◯ Former Smoker **Are you a current smoker?** ◯ Yes ◯ No

Height _____ **Weight** _____ **BP** _____ \ _____

Patient Name_____

REVIEW of SYSTEMS ***(****Have or do you ever experience any of the following signs or symptoms? If yes please describe)*

Sign/Symptom	Yes/No	Please describe all "yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)	◯ Yes ◯ No	
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	◯ Yes ◯ No	
Cardiovascular (e.g. chest pain, palpitations)	◯ Yes ◯ No	
Respiratory (e.g. shortness of breath, cough, snore)	◯ Yes ◯ No	
Gastrointestinal (e.g. ulcer, gastritis, GI bleed)	◯ Yes ◯ No	
Genitourinary (e.g. burning, bleeding)	◯ Yes ◯ No	
Musculoskeletal (e.g. joint, muscle, back or neck pain)	◯ Yes ◯ No	
Skin (e.g. delayed healing, rash, acne, cellulitis)	◯ Yes ◯ No	
Neurological (e.g. numbness, tingling, weakness)	◯ Yes ◯ No	
Endocrine (e.g. weight gain/loss, excess thirst or urine)	◯ Yes ◯ No	
Hematologic (e.g. bruising, bleeding, clotting disorder)	◯ Yes ◯ No	
Allergic/Immunologic (e.g. rash, swelling, wheezing)	◯ Yes ◯ No	
Urinary (e.g. urinary loss of control)	◯ Yes ◯ No	

COMMENTS OR CLARIFICATION

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

Patient Signature **Signed Date**

Guardian Signature ***(if patient is a minor)*** **Signed Date**

Guardian Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.

Any Changes?

◯ Yes ◯ No **Signed** **Date**

◯ Yes ◯ No **Signed** **Date**

◯ Yes ◯ No **Signed** **Date**

Account #

PATIENT INFORMATION

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

Age **Date of Birth**

SSN **Marital Status** ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Address **City** **State** **Zip Code**

Home Telephone **Work Telephone** **Cell Telephone**

Email **May we email you newsletters?** ◯ Yes ◯ No

Preferred Language **Ethnicity** ◯ Hispanic ◯ Non-Hispanic **Race**

PHYSICIANS / PHARMACY

Referring Physician *(First) (Last)* **Telephone**

Primary Care Physician *(First) (Last)* **Telephone**

Pharmacy Name **Telephone**

Address

GUARANTOR

☐ Guarantor Same As Patient **Relationship** **Telephone** **Date of Birth**

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

SSN **Occupation** **Employer**

Address **City** **State** **Zip Code**

PATIENT EMPLOYMENT AND EMERGENCY CONTACT

Employment Status ◯ Working ◯ Retired ◯ Disabled **Emergency Contact**

Occupation **Telephone** **Relationship**

Employer **Do You Have a Living Will or Advanced Directives?** ◯ Yes ◯ No

INSURANCE CARRIERS

	Carrier #1	Carrier #2
Name		
Policy/Claim #		
Group ID		
Policy Holder		
Policy Holder DOB		

Work Related? ◯ Yes ◯ No

Work Comp Insurance **Work Comp Contact**

Insurance Address **Contact Telephone**

Claim #

Insurance Telephone

I hereby authorize Fox Valley Orthopedics to release any information to my insurance company acquired in the course of my examination or treatment. I hereby authorize benefits to be paid directly to them. I authorize them to check pharmacies for my prescription history. I understand I am responsible for any unpaid balance.

Patient Signature *(Guardian if Patient is a minor)* Print Form **Date**

Patient Name_____

PLEASE SIGN & DATE:

I confirm that the privacy policy has been made available to me.

X_____Date:_____

Patient Signature (Guardian if Patient is a minor)

CONFIDENTIAL COMMUNICATION REQUEST

May we leave a message regarding medical information, please check your answer:

On answering machine at home?	☐ Yes	☐ No
With person at your home?	☐ Yes	☐ No
On your voicemail at work?	☐ Yes	☐ No
On your email account?	☐ Yes	☐ No
On your voicemail on your cell phone?	☐ Yes	☐ No

May we speak to a family member regarding your medical status? If so, with whom may we speak?

_____

X_____

Patient Signature (Guardian if Patient is a minor)

May we speak to a family member regarding your financial status? If so, with whom may we speak?

_____

X_____

Patient Signature (Guardian if Patient is a minor)

RELEASE OF LABORATORY & X-RAY INFORMATION

I hereby authorize Fox Valley Orthopedics to give lab, X-Ray, MRI, and CT results to a family member:

X_____

Patient Signature (Guardian if Patient is a minor)

ACKNOWLEDGEMENT REGARDING MEDICAL EQUIPMENT

Not all medical equipment may be paid for by my insurance company. We will let you know which items may not be covered. If my insurance carrier denies payment, I agree to be personally and fully responsible for payment.

X_____

Patient Signature (Guardian if Patient is a minor)

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