

Reviewed by _____

GENERAL MEDICAL INFORMATION
(answering all questions will help us be aware of your general health status)

**Midlands
Orthopaedics, p.a.**

Patient's Full Name _____ Chart # _____ Date: _____
First Middle Last

Age _____ Sex _____ Race _____ Physician's # _____

What is the purpose of your visit today (name body part) _____ RIGHT or LEFT or BOTH SIDES

Date of injury or date of first symptom: _____ Describe: _____

Previous treatment (when and by whom): _____

Were x-rays taken (if so, by whom and when)? _____

Are you **ALLERGIC** to any medications? NO YES Please list them: _____ Betadine
_____ Latex

Where did the injury occur? Home Work Auto School Athletics Motor Cycle Other What State? _____

CURRENT MEDICATIONS, VITAMINS, OR HERBAL SUPPLEMENTS:

LIST ALL SURGICAL PROCEDURES AND ANY HOSPITALIZATIONS IN YOUR LIFETIME:

MEDICAL ILLNESSES: (check the ones you have now or have had in the past)

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Sickle cell treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Sleeping Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney/bladder infection | <input type="checkbox"/> Reflux | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sickle cell anemia | |

Other: _____

SOCIAL HISTORY: (please check) Single Married Divorced Widowed

Do you have children? NO YES # Do you live alone? NO YES

Are you on a special diet? NO YES Describe _____

Do you smoke currently? NO YES Amount: _____ packs/day for _____ years

Have you quit smoking? NO YES Amount: _____ packs/day for _____ years

How much alcohol do you drink? none occasional 1-2 drinks/day more

Work History: (please check one below)

Employed Unemployed Self-Employed Student Homemaker Retired Disabled

Type of work: _____ Employer: _____ Occupation: _____

FAMILY HISTORY: (please check any that have occurred in blood relatives)

- | | | | | | |
|------------------------------------|-----------------------------------|---|--|---------------------------------------|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Stroke | |

If patient is a minor, list all others living in the household and their relationship to the patient: _____

Referring Physician: _____ (FULL NAME) Family Physician: _____ (FULL NAME)

ADDRESS CITY STATE ZIP PHONE ADDRESS CITY STATE ZIP PHONE

Athletic Trainer: (if student athlete) _____ (FULL NAME) School: _____ (FULL NAME)

ADDRESS CITY STATE ZIP PHONE IF NO REFERRING DR. INITIAL HERE _____

REVIEW OF SYSTEMS

Please check any of the following symptoms which apply to you. Use the space provided to describe any detailed history of these problems.

I HAVE NONE OF THE PROBLEMS LISTED BELOW

I. General Health

- Present Weight: _____ Height: _____ Pulse: _____
- Any significant weight change?
 - Loss of appetite?
 - Recent fever?
-

II. Eye, Ear, Nose & Throat

- Recent bad cold or sinus infection?
 - Frequent hay fever symptoms?
 - Seasonal / Year round?
 - Vision trouble?
 - Hearing trouble?
 - Frequent nose bleeds?
-

III. Respiratory

- Shortness of breath?
 - Frequent cough?
 - Wheezing?
 - Do you use a CPAP machine?
-

IV. Cardiac

- Chest pains?
 - Heart murmur?
 - Palpitations/Irregular heart beat?
 - Dizziness/light headedness?
-

V. Skin

- Rash?
 - Psoriasis?
 - Eczema?
-

VI. GI

- Frequent heartburn or indigestion?
 - Frequent nausea or vomiting?
 - Constipation?
 - Diarrhea?
 - Blood in stools or black stools?
 - Jaundice
 - Liver problems
-

VII. Urinary

- Painful urination?
 - Blood in urine or dark urine?
 - Loss of bladder control?
-

VIII. Neurological

- Frequent headaches?
 - Loss of balance?
 - Seizures?
 - Fainting spells?
 - Have you been diagnosed with fibromyalgia, RSD or pain syndrome?
 - Claustrophobia?
-

IX. Hematologic

- Easy bruising and bleeding?
 - Severe blood loss with previous surgery?
 - Anemia?
 - Do you take a blood thinner?
-

X. Anesthesia

- Have you ever had problems with anesthesia?
- No previous problems.
 - Nausea and vomiting?
 - Difficulty opening mouth?
 - Difficulty waking up from surgery?
 - Malignant hyperthermia?
 - Family member had problems?
 - Have you had surgery at Midlands before?
 - Other?
-

XI. Gynecological (females only)

- Menstrual problems?
-
- Last menstrual period? _____
-

XII. Psychiatric

- Depression?
 - Hyperactive ADD?
 - Anxiety?
 - Other?
-

Patient (or patient's guardian) _____

Nurse _____

Doctor _____

Pre-op interview note(s): _____

Nurse's name _____ Date _____

Midlands Orthopaedics, p.a.

Patient Acct. No _____ Doctor _____ Date _____

Is this visit due to an accident?

YES NO **If yes:** ___ Motor Vehicle ___ Work Related ___ Other?

(PATIENT INFORMATION)

LAST NAME	FIRST	MIDDLE INITIAL	DATE OF BIRTH	SOCIAL SECURITY#	MARITAL STATUS	GENDER	
ADDRESS			CITY, STATE, ZIP CODE		HOME PHONE		
PATIENT'S EMPLOYER		PATIENT'S OCCUPATION		FULLTIME OR PART TIME		WORK PHONE	
IS THE PATIENT A STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, NAME AND CITY OF SCHOOL				CELL PHONE	
IN CASE OF EMERGENCY			RELATIONSHIP TO PATIENT AND PHONE #				

(INSURANCE INFORMATION)

INSURANCE #1 (PRIMARY INSURANCE)		INSURANCE #2 (SECONDARY INSURANCE)	
INSURED'S NAME	RELATIONSHIP TO PATIENT	INSURED'S NAME	RELATIONSHIP TO PATIENT
SOCIAL SECURITY # OF INSURED (IF DIFFERENT FROM PATIENT)		SOCIAL SECURITY # OF INSURED (IF DIFFERENT FROM PATIENT)	
DATE OF BIRTH OF INSURED		DATE OF BIRTH OF INSURED	
INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT)		INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT)	
PERSON RESPONSIBLE FOR THE BILL IF THE PATIENT IS A MINOR OR STUDENT		RESPONSIBLE PARTY INFORMATION (ADDRESS, TELEPHONE NUMBER, SSN)	

HAS PATIENT SEEN AN ORTHOPAEDIST / NEUROSURGEON FOR THIS PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS PATIENT HAD X-RAYS FOR THIS PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE _____
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RELEASE OF PRIVATE HEALTH INFORMATION NOTICE / AUTHORIZATION

Copies of your records pertaining to today's visit (and subsequent visits for the same problem) **may be shared with the referring physician, family physician, school athletic director, and/or any other party you list on the "General Medical Information" sheet pertaining to the same problem.** By initialing this, you authorize MOPA to do so; by initialing "restriction", you restrict MOPA from sending medical information without your specific direction.

____ I authorize records be sent as outlined above _____ (patient's initials) _____ (date)

____ I do not authorize the release of my records. The following restrictions apply: _____

MOPA employee initials _____

2008

MIDLANDS

orthopaedics, p.a.

Chart # _____ Name _____

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

1. AUTHORIZATION TO RELEASE MEDICAL / APPOINTMENT INFORMATION

In the event that you are unable to contact our office and need to have someone other than yourself request medical, financial, or appointment information, please list their name(s) below. Without this authorization, we will not be able to disclose any information about you, your appointment, your bill(s), or your treatment at MOPA to anyone but you, the patient, your insurance company or referring/treating physician(s).

Name:	Relationship to you:	Type of Info to Release (appt, medical, financial):

2. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I have been presented with a copy of Midlands Orthopaedics, P.A.'s (MOPA") Notice of Privacy Policies detailing how my protected health information ("PHI") may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my PHI (write "none" if there are no restrictions): _____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

3. NO-SHOW / LATE CANCELLATION FEES

A fee of \$100 will be charged for any MRI appointment that is not cancelled at least 24 hours prior to the appointment time, or for which the patient does not show.

A fee of \$150 will be charged for any ESI (epidural steroid injection) appointment that is not cancelled at least 24 hours prior to the procedure time, or for which the patient does not show.

A fee of \$150 will be charged for any scheduled surgical procedure that is not cancelled at least 24 hours prior to the procedure time, or for which the patient does not show.

Patient / Guardian Signature

Today's date

(acknowledges receipt & understanding of points 1 through 3 on this page)

MOPA employee initials _____ date _____