

# Medical History

Patient Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

List Medical Problems You Have or Had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List All Medications You Take:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Surgeries You Have Had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Allergies to Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a latex allergy? YES NO

Can you Take Anti-Inflammatory Drugs (Ibuprofen, Aleve, Aspirin)? YES NO

List Any Medical Problems in Your Family:

\_\_\_\_\_  
\_\_\_\_\_

What Hobbies Do You Have? \_\_\_\_\_

Do You Play Any Sports Regularly? \_\_\_\_\_

Do You Exercise? \_\_\_\_\_

Are you currently experiencing or have you experienced any of the following:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss or Gain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Wound Healing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Infections
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Taken Prednisone
<input type="checkbox"/>	<input type="checkbox"/>	Drink Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Use Recreational Drugs
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	Colon Screening (Colonoscopy)
<input type="checkbox"/>	<input type="checkbox"/>	Flu Vaccine			

Tobacco Use:  Never  Former  Occasional  Everyday  Light  Heavy

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CURRENT MEDICAL PROBLEM**

Body Part: \_\_\_\_\_

LEFT

RIGHT

Please give us a description of the problem that brings you here for diagnosis and treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes      No

Is this problem related to a specific injury? Date of injury: \_\_\_\_\_

Is this problem related to a work injury? \_\_\_\_\_

Employer at time of injury? \_\_\_\_\_

Is this problem related to a motor vehicle accident? Date of Accident? \_\_\_\_\_

Have you missed work because of this problem? \_\_\_\_\_

When was the last day you worked? \_\_\_\_\_

Have you seen another doctor for this problem?

Who and when: \_\_\_\_\_

Have you had any x-rays, MRI, or CT scan done?

When and where: \_\_\_\_\_

**(TO BE FILLED OUT BY PHYSICIAN)**

Patient Age

R/L Handed

Location

Duration

d / w / m / y

Injury

Quality

ache / sharp / dull

Severity

1.....5.....10

Timing

day / night / work

Context

progressing / improving / no change

Previous

Modifying Factors

PT / HEP

Meds

Injection

Brace

Associated Sx



## Health Insurance Information

PRIMARY Insurance Company: \_\_\_\_\_  
Contract No: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_

SECONDARY Insurance Company: \_\_\_\_\_  
Contract No: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_

Would you like a printed copy of our HIPAA policy Yes No

### Authorizations:

I understand that I will be held responsible for payment for services not covered by my insurance.

I consent to the use or disclosure of my protected health information (PHI) by Rochester Community Orthopaedics, LLP for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Rochester Community Orthopaedics, LLP, and for such other uses that are permitted or required under federal or state law. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

Medicare: The information given by me in applying for payment under Title XVIII of the Social Security Administration Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims for payment purposes.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Relationship to Patient: \_\_\_\_\_  
(If other than patient)

### Please fill out this section if the patient is less than 18 years of age:

Father's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_