The Orthopaedic Group, a division of Connecticut Orthopaedic Specialists

PATIENT MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Age: _____ **Height:** _____ **Weight:** _____ ☐ **Male** ☐ **Female** ☐ **Right** ☐ **Left Handed**

Onset: Date of injury - or - Onset of symptoms: / /

Please describe the specific orthopaedic problem for which you are being evaluated today? ☐ Rt / ☐ Lt

How did this occur?

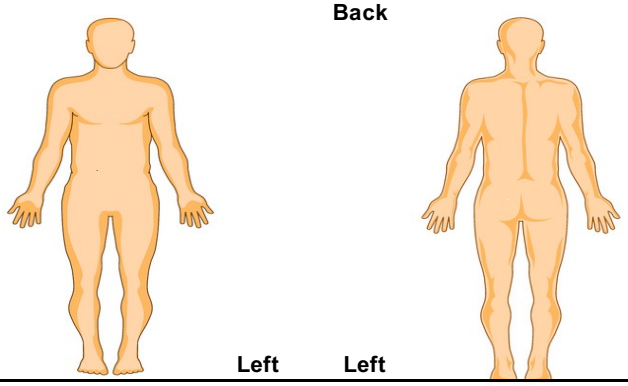
Is this a: ☐ Motor Vehicle Accident ☐ Liability case ☐ Work Injury ☐ Sports ☐ Other:

Job Title & Specific Duties:

Working now? ☐ Yes ☐ No (if not, why):

Utilizing the Diagram below, please indicate the location and side of your pain:

Front **Back**



Right **Left** **Left** **Right**

Describe the quality/intensity of pain (select one from each category):

☐ **dull** ☐ **throbbing** ☐ **sharp**
☐ **mild** ☐ **moderate** ☐ **severe**

Is your pain constant? ☐ **Yes** ☐ **No**
Does it come & go? ☐ **Yes** ☐ **No**

Since symptoms began has pain:
☐ **Improved** ☐ **Worsened** ☐ **No Change**

Duration and frequency of your pain?

What improves it? (eg. rest, cold, limb elevation):

What worsens it? (eg. activities or position):

Does it radiate/move to other locations? **Where?**

When is your pain the worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Awaken from sleep

Have you had any: ☐ Locking ☐ Giving away ☐ Bruising ☐ Numbness ☐ Tingling ☐ Redness ☐ Warmth
☐ Swelling ☐ Fever ☐ Or any other symptoms?

Have you: **Injured** this area before?

Had X-rays or other **test**s done? Where? When?

Hospitalization or **Surgery** for this problem? Where? When?

Therapy or **splinting**?

Do you use a? ☐ cane ☐ crutches ☐ walker

Any **other** orthopaedic problems?

Have you or a relative had treatment here before?

If you are being seen for a BACK problem: Have you had any change in or problems with:

Bowel/bladder control ☐ Yes ☐ No Sexual function ☐ Yes ☐ No

Current Medical Problems:

Past Surgeries:

List all Current Medications:

Name and address of preferred pharmacy:

LIST **ALL ALLERGIES** to Food or Medication:

Any **Family History** of heritable musculoskeletal or connective tissue disorders? ☐ **No** ☐ **Yes**

REVIEW OF SYSTEMS: Do you have any problems with the following: Check Yes or No

Eyes	☐ Yes	☐ No	Blackouts/Fainting/Balance	☐ Yes	☐ No
Ears/Nose/Throat	☐ Yes	☐ No	Psychological	☐ Yes	☐ No
Lungs	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Heart/Circulation/Vascular	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Stomach/Heartburn/Ulcers	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Bowel Problems	☐ Yes	☐ No	Polio/TB	☐ Yes	☐ No
Hepatitis/Liver	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Kidney/Bladder	☐ Yes	☐ No	Allergic/Immunological	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Skin/Rash	☐ Yes	☐ No
Blood/Bleeding Problems	☐ Yes	☐ No	Prednisone/Steroid Use	☐ Yes	☐ No
Diabetes/Thyroid	☐ Yes	☐ No	Blood Clots (legs-lungs)	☐ Yes	☐ No
Recent Infections	☐ Yes	☐ No	Other (please explain)	☐ Yes	☐ No

Explain all marked with a "YES" answer:

Do you smoke? ☐ Yes ☐ No Packs/day:

Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown
☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

Drink Alcohol? ☐ Yes ☐ No Drinks per day:

Please list hobbies/special interests:

What activities does your current condition prevent you from?

Name of Doctor requesting consultation:

Primary Doctor Name/Location:

Attorney for this problem ☐ Yes ☐ No Name/Address:

How often do you exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Type-Unknown ☐ White

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Type-Unknown

Language:

Marital status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No How many? Do you live alone? ☐ Yes ☐ No

Patient's signature:

Reviewed By: **MD** **Date:**

Physical exam: Temperature: Pulse: BP:

Medical Records Reviewed By: MD on / /

Revised: 03/07/2013/ jan 2016 MD on / /

The Orthopaedic Group, a division of Connecticut Orthopaedic Specialists
Patient Information Form

Patient: _____ Birthdate: _____ SS# _____-_____-_____

Address: _____ City: _____ ST_____ Zip: _____

Home Phone: _____Work Phone: _____

Cell Phone: _____ E-Mail: _____

Primary Doctor: _____ Address: _____ Phone: _____

Employer: _____ _Address:_____

Spouse Name: _____ Birthdate: _____SS#_____-_____-_____

Spouse Employer: _____ Phone: _____

Next of Kin not living with you:
_____Phone:_____

Emergency Contact:
_____Phone:_____

RESPONSIBLE PARTY: (If you are legal guardian or if patient is a minor or student)
Name: _____Address: _____

INSURANCE INFORMATION:
PRIMARY: _____ ID# _____
GRP#_____
Who subscribes to insurance: _____ Birthdate: _____

SECONDARY:
_____ID#_____GRP#_____

Who subscribes to insurance: _____ Birthdate: _____

If your Insurance plan requires a ***written referral*** from your primary doctor, one must be obtained BEFORE the appointment or you will be rescheduled- NO EXCEPTIONS

SIGNATURE REQUIRED-PLEASE READ:
As per your contract and ours with your insurance company, copays are due at the time of visit.Please be prepared to pay at time of check in. We accept cash, credit card and personal checks.

Regardless of any insurance coverage I/we may or may not have, it is my/our responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I/we agree to pay costs and attorney fees as allowable by law and acknowledge receipt of this agreement. I give authorization to release my medical records for billing purposes.
SIGNATURE: _____DATE: _____

MEDICARE PATIENTS ONLY, Please read & sign:

I request that payment under the Medicare/Metrahealth insurance program be made directly to Connecticut Orthopaedic Specialists, of which The Orthopaedic Group is a division of, on any bills for services rendered by their physicians during my lifetime. I understand that I may be held responsible for a portion of these bills after Medicare has paid the provider, or for charges Medicare does not cover.

SIGNATURE: _____ DATE: _____