SUN CITY
ORTHOPAEDIC &
HAND SURGERY SPECIALISTS

Office: (915) 581-0712 | Fax: (915) 833-7312

MEDICAL HISTORY QUESTIONNAIRE

Patient's
Name: _____ DOB: _____ Age: _____ Date: _____

Referring Doctor: _____ ☐ Right Handed ☐ Left Handed

Preferred Pharmacy: _____

1. CHIEF COMPLAINT (brief statement): *(example: I fell down and hurt my knee)*

Date of Injury/Onset: _____

Body Part:_____

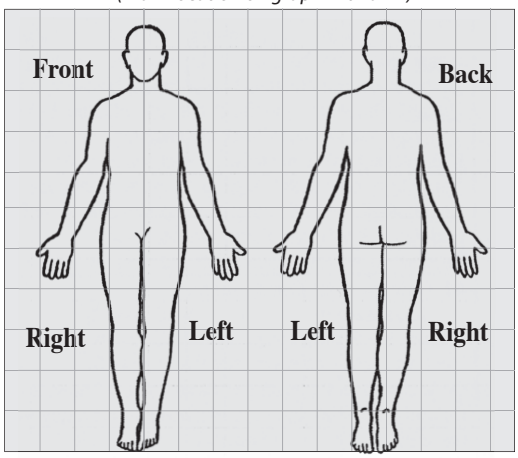
_____

_____

_____

Duration: *(How long have you had this problem?)*_____

Location: *(mark location on graph with an X)*

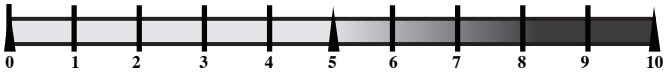


Pain Severity:

☐ Mild

☐ Moderate

☐ Severe *(Circle Number)*



Modifying Factors:

What makes it better? _____

What makes it worse? _____

If you can remember, please list the doctor(s) name(s) and approximate dates when they saw you for this problem:

_____

_____

_____

Please list any tests that have been performed for this injury:

☐ X-ray(s) ☐ MRI ☐ EMG ☐ CAT scan ☐ Ultrasound ☐ Bone Scan ☐ Other _____

Please list any treatments that have been performed for this injury:

☐ Chiropractic Adjustments ☐ Work Hardening ☐ Massage ☐ Pain Clinic ☐ Physical Therapy How long? _____

Please list medications or types of medicines you have been given to treat this condition: How long? _____

_____

Have you ever injured this area of your body before? ☐ Yes ☐ No If yes, give approximate date: _____

2. MEDICAL HISTORY - X appropriate History responses:

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bladder Problems
☐ Bleeding Disorder
☐ Blood Clots
☐ Cancer
☐ Chest Pain
☐ Chronic Back Pain
☐ Chronic Kidney Disease
☐ Congestive Heart Failure
☐ Depression
☐ Diabetes
☐ Diabetic Foot Ulcers
☐ Dialysis
☐ Diverticulitis
☐ Emphysema
☐ GI Bleed
☐ Gatritis
☐ Gout
☐ Heart Attack
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Irregular Heart Beat
☐ Liver Problems
☐ Lupus
☐ Migraines
☐ Neurological Disorder
☐ Numbness/Tingling
☐ Osteoporosis
☐ Peptic Ulcer
☐ Poor Circulation
☐ Pulmonary Embolism
☐ Reflux
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sleep Apnea
☐ Stroke/TIA
☐ Thyroid Disease
☐ Urinary Tract Infection (Chronic)
☐ Weight Loss
☐ None of the Above

3. SURGICAL HISTORY (X major operations):

☐ Amputation	☐ Carpal Tunnel	☐ Knee Replacement	☐ Rotator Cuff Repair
☐ AV Fistula Creation	☐ Cataract Extraction	☐ Kyphoplasty	☐ Tonsillectomy
☐ AV Graft	☐ Cholecystectomy	☐ Lumpectomy	☐ Tunneled Dialysis Catheter
☐ Aortic Valve Replacement	☐ Colon Resection	☐ Mastectomy	☐ Urinary incontinence surgery
☐ Appendectomy	☐ Craniotomy	☐ Mitral Valve Replace	☐ Vertebroplasty
☐ Coronary Bypass	☐ Gastric Bypass	☐ Nephrectomy: Native	☐ Anesthesia Prob-No
☐ Back surgery	☐ Hemorrhoidectomy	☐ Nephrectomy: Transplant	☐ Anesthesia Prob-Yes
☐ Bronchoscopy	☐ Hip Replacement	☐ Pacemaker	☐ Surgical Complications-No
☐ C-Section	☐ Hysterectomy	☐ Parathyroidectomy	☐ Surgical Complications-Yes
☐ CABG	☐ Interventional Pain Procedures	☐ Pneumonectomy	☐ Post-op delirium
☐ Carotid Endarterectomy	☐ Knee Arthroscopy	☐ Prostatectomy	

_____

_____

4. FAMILY HISTORY - X appropriate History responses:

☐ Anesthesia Prob	☐ Bleeding Disorder	☐ Diabetes	☐ Osteoporosis	☐ TB
☐ Arthritis	☐ Blood Clots	☐ Heart Disase	☐ Rheum Arthritis	
☐ Asthma	☐ Cancer	☐ HTN	☐ Stroke/TIA	

5. SOCIAL HISTORY

Maritial Status: ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated Children: ☐ Yes ☐ No

Work Status: ☐ Retired ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Employed

If employed; Employer: _____ Type of Work: _____

How long have you been employed by this company? _____

Smoker: ☐ Current ☐ Former ☐ Never

Smokeless Tobacco: ☐ Current ☐ Former ☐ Never

Caffeine Use: ☐ Yes ☐ No How much caffeine do drink per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No Type and quantity _____

6. IMPLANTABLE DEVICES - X appropriate History responses:

☐ Pacemaker ☐ Stents

7. REVIEW OF SYSTEMS - **<u>Are you presently having problems with any of the systems listed below</u>**:

<u>General:</u> weight loss, fatigue, fever, chills, night sweats
<u>Eyes:</u> glasses, contact lenses, blurriness, double vision/diplopia, eye pain, redness
<u>Ears:</u> hearing loss, ringing, hearing aid, dizziness
<u>Mouth/Throat:</u> bleeding gums, sore throat, dental problems
<u>Neck:</u> swelling, neck lumps
<u>Respiratory:</u> shortness of breath/dyspnea, wheezing, cough, hemoptysis/spitting blood
<u>Cardiac:</u> murmurs, chest pain, palpitations, difficult or labored breathing/dyspnea
<u>GI:</u> hemorrhoids, black tarry stool, vomiting of blood, abdominal pain, jaundice, blood in stool
<u>Urinary:</u> frequency, painful, difficult urination, blood in urine, incontinence, infection
<u>Skin:</u> rashes, sores, lumps, bruising
<u>Neurologic:</u> numbness, tingling, tremors, weakness, paralysis, seizures
<u>Psychiatric:</u> anxiety, depression, memory loss
<u>Hematologic:</u> easy bruising/bleeding, transfusions

☐ Not currently experiencing any problems in any of the systems above

8. VITALS

Drug Allergies (example: penicillin, iodine, tape, latex) (examples of side effects: rash, swelling, difficulty breathing): ☐ No Known Drug Allergies

_____

Medications (list names of medications or types of medications which you are currently taking): ☐ Not currently taking any medications

_____

_____

FOR INTERNAL USE ONLY

TEMP: _____ BP: _____ PULSE: _____ HEIGHT: _____ WEIGHT: _____ BMI: _____

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

HIPAA Official:

Sun City Orthopedic and Hand Surgery Specialists

Sun City Orthopaedic and Hand Surgery Specialists reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for **Sun City Orthopaedic and Hand Surgery Specialists**

_____

Name of Patient (Print or Type) **DOB**

AUTHORIZATION:

I hereby consent to any necessary medical treatment for myself or the minor child named above for whom I am legally responsible.

I permit payment directly to **Sun City Orthopaedic and Hand Surgery Specialists** for any benefits due for services rendered. I understand that I am responsible for all charges, whether or not covered by my insurance company.

MEDICAL RECORDS:

Authorization is hereby granted for release of any information required to process insurance claims. A copy of this authorization is as valid as the original. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

I also hereby authorize **Sun City Orthopaedic and Hand Surgery Specialists** to furnish or disclose any information in regard to my illness or treatment to any insurance company, government agency, employer, health professional or attorney.

_____

Signature of Patient **Relationship of Patient Representative to Patient**

_____

Signature of Patient Representative **Date**

(Required if the patient is a minor or adult who is unable to sign this form)

SUN CITY
ORTHOPAEDIC &
HAND SURGERY SPECIALISTS

Date:_____

PATIENT DEMOGRAPHICS

How did you hear about us? Social Media_____Friend_____Referring Dr_____Other_____

Patient Name: _____DOB:_____**Social Security #:** ____-_____-_____
(Nombre del Paciente) **(Fecha De Nacimiento)** **(Seguro Social)**

Mailing Address: _____**Primary Phone:** _____
(Direccion) **(Telefono)**

City/State:_____**Zip Code:** _____
(Ciudad/Estado) **(Codigo Postal)**

Email: _____**Martial Status:**_____
(Correo Electrónico)

Referring Doctor: _____**Phone #:**_____
(Médico de Referencia) **(Telefono)**

Preferred Pharmacy:_____**Phone #:**_____
(Farmacia Preferida) **(Telefono)**

Address:_____ **Cross Street:**_____
(Dirección) **(Intersección)**

Employer: _____**Employer Phone #:** _____
(Empleo) **(Telefono)**

Did you get injured at work?_____**Occupation:** _____
(Se lastimó en el trabajo?) **(Ocupación)**

Primary Insurance:_____ **Secondary Insurance:**_____
(Aseguranza Primaria) **(Aseguranza Secundaria)**

Policy Holder Name:_____**DOB:**_____ **SSN:**_____-_____-_____
(Titular de Poliza) **(Fecha De Nacimiento)** **(Seguro Social)**

Responsible Party:_____**DOB:**_____**SSN:**____-_____-_____
(Persona responsable) **(Fecha De Nacimiento)** **(Seguro Social)**

Spouse Name: _____ **Phone:** _____
(Nombre de Esposa/Esposo) **(Telefono)**

Emergency Contact: _____**Phone:** _____
(En caso de emergencia Notificar a) **(Telefono)**