

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

### Medical History Questionnaire

ALLERGIES: (including drugs/or metals) \_\_\_\_\_

#### Social History

Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status \_\_\_\_\_  
Alcohol Use? (Type & Amount) \_\_\_\_\_ Tobacco Use? (Type & Amount) \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Primary Care Phone # \_\_\_\_\_

#### Family Medical History

*Have any of your blood relatives had: (check all that apply)*

\_\_\_\_\_ Diabetes                      \_\_\_\_\_ Rheumatoid Arthritis                      \_\_\_\_\_ Malignant Hyperthermia  
\_\_\_\_\_ Cancer                      \_\_\_\_\_ Heart Disease                      \_\_\_\_\_ Blood Clots

#### Past Medical History

_____ Osteoarthritis	_____ Rheumatoid Arthritis	_____ Headaches	_____ Stroke/CVA/TIA's	_____ Seizures
_____ Sleep Apnea	_____ Glaucoma	_____ Anxiety/Depression	_____ Asthma	_____ Emphysema/COPD
_____ High Blood Pressure	_____ Heart Condition	_____ Blood Clots	_____ Blood Transfusion	_____ Thyroid Disorder
_____ Breathing Problems	_____ Acid Reflux	_____ Diabetes	_____ Neuropathy/Cold hands/feet	_____ Hepatitis
_____ HIV/AIDS	_____ Liver Disease	_____ Kidney Stones	_____ Kidney Disease	_____ Intestinal Disorders
_____ Fibromyalgia	_____ Prostate Disease	_____ Treatment for Drug/Alcohol Abuse	_____ Cancer What type?	_____ Anesthesia Complications

#### Current Medications

*(Please include prescriptions, over the counter medications, vitamins and supplements)*

Name of Medication	Dosage	Name of Medication	Dosage	Name of Medication	Dosage

#### Surgical History

*(List all dates of Hospitalization and/or Surgeries)*

Date:	Type of Surgery:	Any Complications?

**\*\*Please turn over to complete your medical history\*\***

## Review of Systems

(Please **CIRCLE** all positive symptoms and describe if needed)

- |     |   |  |
|-----|---|--|
| 1.  | Constitutional: Fever, weight gain/loss, loss of appetite                             | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2.  | Eyes: Double vision, blurring, difficulty seeing                                      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3.  | E.N.T.: Deafness, Sinusitis, hoarseness, vertigo                                      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 4.  | Cardiovascular: Chest pain, palpitations, irregular/rapid heartbeats, murmur          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 5.  | Respiratory: New shortness of breath  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 6.  | Digestive: Nausea, diarrhea, indigestion  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 7.  | Urologic: New urinary pain, sudden or increase in frequency                           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 8.  | Prostate (men): Enlarged Prostate/BPH, Prostate Cancer                                | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 9.  | Skin: Rashes, lesions that do not heal, changes in moles                              | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 10. | Neuro: Seizures, loss of balance/coordination, paralysis, weakness, or loss of memory | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 11. | Psychiatric: Depression, anxiety, hallucinations, sleep disturbances                  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 12. | Endocrine: Excessive thirst/urination, heat/cold intolerance                          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 13. | Blood/Lymphatic System: Anemia, Bleeding tendencies, swollen lymph nodes              | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 14. | Allergic and immunologic: Hives, eczema, itching                                      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 15. | Musculoskeletal: Stiffness, joint pain, deformity, atrophy of muscles, back pain      | <input type="checkbox"/> No <input type="checkbox"/> Yes |

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Hendersonville Orthopedics

## Patient Information:

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

Last Name:		First Name:	Middle:	Social Security:
Mailing Address:		City:	State:	Zip:
Maiden Name:	Home Phone:		Work Phone:	
Cell Phone:			Date of Birth:	Gender: (Circle) Male    Female
Emergency Contact/Relationship to Patient:			Emergency Contact Phone:	

## Patients Legal Guardian (Mandatory if patient is under 18):

Parent/Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

## Insurance Information:

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
Card Holders Name: \_\_\_\_\_ Card Holders Date of Birth: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
Referring Physician's Phone Number: \_\_\_\_\_

What is your primary complaint for coming to see us today? \_\_\_\_\_

Have you had any X-rays taken for this problem? \_\_\_\_\_

Is this the result of an injury?  Yes  No      If yes, what's date of injury? \_\_\_\_\_

Were you injured on the job?  Yes  No      Date Last Worked: \_\_\_\_\_

Were you injured in an auto accident:  Yes  No      Date of MVA: \_\_\_\_\_

I certify the information on this form is true to the best of my knowledge. I give my permission to Hendersonville Orthopaedics to provide health care to myself or the above named dependent.

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

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

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

**Insurance/Medicare Lifetime Authorization for Payment/Information Release**

1. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Hendersonville Orthopedics, PLLC and authorize Hendersonville Orthopedics, PLLC to submit a claim to my insurance carrier or Medicare for payment. I authorize any holder of medical information about me to be released to the health care financing administration and its agents and information needed to determine these benefits or the benefits payable for related services.
2. As a courtesy to you, we will bill your insurance company if we are a participating provider. If you have a co-pay or a deductible, please be prepared to pay at the time of appointment. **Payment is due at time of service.** I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.
3. I have received and reviewed a copy of Hendersonville Orthopedics Notice of Privacy Practices. Hendersonville Orthopedics reserves the right to revise its Notice of Privacy Practices at anytime.
4. About X-rays: All x-rays are the property of Hendersonville Orthopedics. X-rays are part of your medical file and must be maintained as part of your medical record. Copies can be provided at a nominal charge. Requests must be made in writing, allowing enough time to mail x-rays if needed.
5. I give my permission to Hendersonville Orthopedics, PLLC to provide health care to myself or my dependent.

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

**MEDICATION POLICY**

1. Please call 24 to 48 hours before you are out of medication.
2. Any requests after 3:00 p.m. will be addressed the following business day.
3. I understand that I must take the medicine(s) precisely as prescribed.
4. I understand that it is illegal to give or sell to another person any medication.
5. I understand that my health care provider will NOT replace lost or stolen medication.
6. I understand consumption of alcohol while taking this medication is extremely dangerous and could cause death.
7. I understand that my health care provider must be notified if I obtain this medicine from another source including, but not limited to: other healthcare providers, hospital emergency rooms and urgent care centers.

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