HEALTH HISTORY FORM

Patient Name _____Birth Date _____ Date _____

□ Female □ Male Age _____ Height_____ Weight _____ Dominant Hand □ R □ L

What is the reason for this visit □ Pain □ Numbness □ Weakness □ Swelling □ Stiffness

□Other _____

How long ago did your symptoms start _____ □ Days □ Weeks □ Months □ Years

Have you had a problem like this before □ Y □ N

Who requested that you visit this office _____

What body part is involved? *Mark below*

□ **Neck**: Radiates into:

□R arm □L arm □None

□ **Back**: Radiates into:

□ R leg □L leg □ None

Shoulder: □R □L

Arm: □R □L

Elbow: □R □L

Wrist: □R □L

Hand: □R □L

Finger: □R: 1, 2, 3, 4, 5

□L: 1, 2, 3, 4, 5

Hip: □R □L

Knee: □R □L

Pelvis: □R □L

Leg: □R □L

Ankle: □R □L

Foot: □R □L

Toe: □R: 1, 2, 3, 4, 5

□L: 1, 2, 3, 4, 5

Check one box which best describes how your problem started.

□ No Injury (Onset was: □Gradual or □Sudden)

□ Injury

□ Injury at work Date_____

□ Work Related (Without Injury)

□ Auto Accident Date_____

Briefly describe Injury:

On a scale of 0 to 10 (10 is the worst) how severe is your pain?

0 1 2 3 4 5 6 7 8 9 10

Please answer questions below regarding your injury:

Do you have any of the following?

□ Swelling □Bruising □ Numbness □ Tingling □ Weakness □ Loss of control of bowel or bladder

Is your pain? (circle all that apply) Sharp Dull Stabbing Throbbing Aching Burning

The pain is? □ Constant □ Comes and goes. Does the pain wake you up at night? □Y □ N

Are your symptoms? □Getting better □ Getting Worse □ Unchanged

What makes your symptoms **worse?** □ Standing □ Walking □ Lifting □ Exercise □ Lying in bed

□ Bending □ Squatting □ Kneeling □ Stairs □ Sitting □ Coughing □ Sneezing

What makes your symptoms **better?** □ Rest □ Ice □ Heat □ Other

What medications are you taking or have taken for this problem?_____

Did you bring any imaging studies? □Y □N

If Yes,

□ X-RAY □ MRI □ CAT scan □ Bone Scan □ Nerve test

Have you had any previous treatments for this problem? (*circle those that apply)*

Injection Brace Surgery Physical Therapy Cane/Crutch

Were you seen in the E.R. for this problem? □Y □N Which E.R. _____ Date _____

Have you already had surgery for a problem in this same area either recently or in the past? □Y □N

Procedure _____Surgeon _____ Hospital_____Date_____

Current work status? □ Regular □ Light Duty □ Not working due to this problem □ Disabled □ Retired

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: □ Disability □ Workman's Comp □ Unemployment

Past Medical History

Have you ever had, or are currently treated for any of the following: *Circle those that apply*

Arthritis	Cancer	Acid Reflux	Other_____
Gout	Stroke	Fibromyalgia	
**Diabetes	Hepatitis	Osteoporosis	
High Blood Pressure	Thyroid Disease	Liver Disease	
Elevated Cholesterol	Asthma	Stomach Ulcers	
Restless Leg Syndrome	AIDS or HIV	Anemia	
Tuberculosis	Bleeding Disorder	Neuropathy	
Heart Disease	Kidney Disease	Blood Clots	

**Diabetes: □ Diet controlled □ Oral medications □ Insulin *circle one* Type 1 or Type 2

Previous Hospitalizations:

Previous Surgeries:

Medications (Include non-prescription)**:**

Allergies(Please list)**:** Drug, Latex, etc.

You may receive Anti-inflammatory pills as a result of this visit. Has any physician instructed you **NOT** to take anti-inflammatory medications? □ Y □ N, If yes, why _____

Have you ever had a reaction to Anesthesia? □ Y □ N

Do you have any artificial parts ? □ Y □ N

Have you experienced any of the following symptoms in the last 6 months?

Circle all those that apply and explain in space to the right

Weight loss/gain	Palpitations	Headache
Frequent fevers	Acid Reflux	Depression
Dizziness	Multiple joint aches	Cough
Seizures	Swelling of joints	Weakness
Loss of appetite	Shortness of breath	Drug/Alcohol addiction
Changes in vision	Painful urination	Sleep Disorder
Hearing loss	Blood in urine	Easy Bleeding/ Easy Bruising
Trouble swallowing	Frequent Rashes	Loss of consciousness
Hoarseness	Skin Ulcers	Anemia

Chest pain Psoriasis Blood in stool

Family History
Have any of your direct relatives (father, mother, siblings, children) had any of the following conditions:

□ Rheumatoid Arthritis □ Hypertension □ Diabetes □ Heart Disease □ Other_____

Social History
Use of tobacco □Y □N

If yes, **Packs per day_____ for _____years**

Use of alcohol Never Rarely Moderately Daily

Marital History: M S D W

Occupation_____ Employer_____

Do you like your job? □Y □N

Do you plan to be working 6 months from now? □Y □N

_____	_____	_____	_____	_____
Signature of patient/parent/guardian	**Date**	**MD/PA Initials**	**Review # 1**	**Review #2**

Acknowledgement of Receipt of Notice
Of Privacy Practices for Protected Health Information
Effective April 14, 2003

Acknowledgement of Receipt; I, the undersigned patient, or personal representative of the patient named below, acknowledge that I have received a copy of Norristown OrthopaedicAssociates, Inc. current Notice of Privacy Practices for Protected Health Information on the date set forth below. A copy of the privacy policy is available in the waiting room.

_____ _____

Printed Name of Patient

Printed Name of Personal Representative, If applicable

_____ ___/___/_____ _____

Signature Date Relationship of above person to patient

Financial Policy

PAYMENT IS DUE AT THE TIME OF SERVICE

Checks returned from the bank are subject to a $25.00 service fee.

Account delinquent more than 90 days from the date of billing may be sent to collection. If your account is sent to collection, you will be responsible for additional fees, which will be added to the account balance owed. For account balances under $50.00, an additional collection fee due of $25.00 will be added to your account. For balances of $50.00 or more, a fee will be added to your account of 28% of the outstanding balance owed. You may also incur additional charges relating to court costs and attorney's fees.

Please be aware that there will be a $20.00 no show fee for missed appointment, or appointments not cancelled within 24 hours. The no show fee increases to $50.00 for a new back patient evaluation.

I have read, understand, and acknowledge the above financial policies and statements.

_____ ____/____/_____

Signature Date

_____

Printed Name

Norristown Orthopaedic Associates, Inc.

Name (please print): _____

Date of Birth: ____ / ____ / _____

In addition to the release of my medical information as stated in Norristown Orthopaedics, Inc. Notice of Privacy Practices for Protected Health Information, NOA has my permission to discuss/disclose my medical information with/to the following person (spouse, son daughter, etc.).

Print Name	**Relationship to You**	**Phone #**

Telephone Communication:

I authorize the following methods of medical communication to myself. (Please complete all that apply.) Please specify by checking yes or no if a message may be left on an answering machine and/or voicemail. Please check box to the left to indicate your preferred contact number.

			Voicemail	
☐	**Home Phone**	_____	**Yes** ☐	**No** ☐
☐	**Cell Phone**	_____	**Yes** ☐	**No** ☐
☐	**Work Phone**	_____	**Yes** ☐	**No** ☐

Name: _____Date of Birth: ___/___/_____
Email address (For informational updates from our office. Not for patient related communications):
_____

Pharmacy Information

Retail Pharmacy:_____
Address:_____
Phone:_____

Mail Order Pharmacy:_____
Fax Number:_____

Name: _____ Date of Birth ___/___/_____
Email address (For informational updates from our office. Not for patient related communications):
_____

Pharmacy Information

Retail Pharmacy:_____
Address:_____
Phone:_____

Mail Order Pharmacy:_____
Fax Number:_____