PERSONAL HISTORY

Name:_____ Date_____ S.S.#_____

Address:_____

City: _____ State _____ Zip code _____

Home phone _____ Cell _____ Other:_____ E-Mail_____

Date of Birth _____ Age _____ Sex ☐ Male ☐ Female

Business/Employer _____

Address _____

Type of Work _____ Years Employed _____

Check One ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ # of Children _____

Name of Emergency Contact _____ Relation _____ Phone _____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Workmans' Comp ☐ Medicare ☐ Medicaid ☐ Auto ☐ Commercial

☐ Personal Health Insurance ☐ Other _____

Please answer the following Government Question:

What is your race: ☐ Caucasian ☐ Black ☐ Asian ☐ Pacific Islander ☐ Hispanic ☐ Refused to answer

What is you Religion: _____ What is your Native language? _____

CURRENT HEALTH CONDITION

Purpose of this Appointment _____

_____

Hospital or doctors seen for this condition _____

_____

When & how did this condition begin (describe)_____

_____

If disabled from work please give dates_____

If ☐ Job related ☐ Auto related ☐ Other_____

Are you presently taking any medication ☐ Yes ☐ No _____

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? _____

_____

Do you have health insurance? ☐ Yes ☐ No

Name of the Insured _____ Relation to insured_____ Insured DOB: _____

Name of Company _____

Policy # _____

Do you have any other type of insurance? ☐ Yes ☐ No Type:_____

Are you covered by Medicare? ☐ Yes ☐ No

If yes, Medicare # _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Suburban Orthopaedic and Medical Center, LLC will prepare any necessary reports and forms to assist me in making any collections from the insurance company and that any amount authorized to be paid directly to **Suburban Orthopaedic and Medical Center, LLC** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care of treatment, any fees for professional services rendered by me will be immediately due and payable.

I _____swear that on _____ ,I sustained injuries due to:

Check One ☐ Motor Vehicle Accident ☐ Bus Accident ☐ Slip and Fall ☐ Other _____

☐ I have received and reviewed my notice of privacy

Patient Signature _____Date: _____

Guardian or Spouse's Signature _____ Date: _____

Doctor's Signature _____

I am aware that I may be subject to criminal prosecution and civil penalties if the above information is not true.

Name:_____ Date:_____

Medical History

Past Medical History

Please check if you have had any of the following:

- □ Alcoholism
- □ Anemia
- □ Anxiety
- □ Arrhythmia
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation
- □ Bronchitis
- □ CAD
- □Cancer Type:_____
- □ Cardiovascular Disease
- □ CHF
- □ Crohn's Disease
- □ Cirrhosis
- □ Colitis
- □ Constipation
- □ COPD
- □ CRF
- □Other_____
- □ CVA
- □ Dementia / Alzheimer's
- □ Disc Disease
- □ DJD
- □ Depression
- □ DM Type I
- □ DM Type II
- □ Emphysema
- □ Epilepsy
- □ Fracture
- □ GERD
- □ Glaucoma
- □ Hepatitis
- □ High Cholesterol
- □ Hyperlipidemia
- □ Hypertension
- □ Implanted Medical Devices
- □ Kidney Disease
- □ Allergies _____
- □ Liver Disease
- □ Migraine
- □ Multiple Sclerosis
- □ Nephrolithiasis
- □ Obesity
- □ Osteoarthritis
- □ Osteoporosis
- □ Prior MI
- □ Pulmonary Disease
- □ Rheumatoid Arthritis
- □ Seizures
- □ Sickle Cell Disease
- □ STD
- □ Thyroid Disease
- □ TIA
- □ Tuberculosis
- □ Ulcers
- □ Valve Problems

Reaction _____

Is there any chance you may be pregnant? ☐Yes ☐No Last date of menses: _____

Past Surgical History

Please check if you have had any of the following:

- □ No prior surgical history
- □ Appendectomy
- □ D&C
- □ Hysterectomy
- □ Knee Arthroscopy
- □ Mastectomy
- □ Shoulder surgery
- □ Spinal Surgery
- □Tonsillectomy
- □ Total Knee Replacement
- □ Total Hip Replacement
- □ Tubal Ligation
- □ Other _____

Preventive Care

Have you had any of the following? If so, please provide the date.

- □ Last Complete Physical Exam ___/___/___
- □ Colonoscopy ___/___/___
- □ Flexible Sigmoidocopy ___/___/___
- □ PSA ___/___/___
- □ Stool Occult Blood ___/___/___
- □ Stress Test ___/___/___
- □ Routine Eye Exam ___/___/___
- □ Dilated Eye Exam ___/___/___
- □ Foot Exam ___/___/___
- □ HPV
- □ Other _____
- □ Bone Density ___/___/___
- □ Mammography ___/___/___
- □ Chlamydia Screening ___/___/___
- □ HIV Testing ___/___/___
- □ Flu Vaccine ___/___/___
- □ Pneumovax ___/___/___
- □ Zoster Vaccine ___/___/___
- □ Tdap Vaccine ___/___/___
- □ TD ___/___/___
- □ Tuberculin PPD ___/___/___

General Family History

- □ Ankylosing Spondylitis
- □ Arthritis
- □ Alcoholism
- □ Anemia
- □ Anxiety
- □ Asthma
- □ Bleeding Disorder
- □ CAD
- □ MI's
- □ CHF
- □ Other _____
- □ Colitis
- □ COPD
- □ Crohn's Disease
- □ CVA / TIA
- □ Depression
- □ Diabetes
- □ Epilepsy
- □ GERD
- □ Gout
- □ Hypertension
- □ Kidney Disease
- □ Liver Disease
- □ Osteoarthritis
- □ Osteoporosis
- □ Psoriasis
- □ Pulmonary Disease
- □ Renal Disease
- □ Rheumatoid Arthritis
- □ SLE
- □ Thyroid Disease

Name:_____ Date:_____

Review of Systems

Please check if you have the following symptoms:

Constitutional

□ Loss of appetite □ Recent change in weight □ Fatigue (Tired)
□ Fever □ Chills □ Night Sweats
□ Able to perform ADL's independently □ Change in sleep habits
□ Other symptoms _____

Head & Neck

□ Headache □ Vision Problems □ Eye Pain
□ Ear pain □ Hearing difficulty □ Sinus Problems
□ Difficulty Swallowing □ Neck Stiffness □ Goiter
□ Other symptoms _____

Cardiovascular

□ Chest Pain □ Ankle edema □ Cold hands or feet
□ Palpitations □ Heart murmur □ Claudication
□ Other symptoms _____

Respiratory

□ Persistent cough □ Productive cough □ Shortness of breath
□ Dyspnea (Difficulty Breathing) □ Orthopnea □ Chest congestion
□ Other symptoms _____

Gastrointestinal

□ Nausea □ Vomiting □ Diarrhea
□ Constipation □ Hematochezia □ Abdominal Pain
□ Other symptoms _____

Genitourinary

□ Frequency □ Burning on urination □ Incontinence
□ Hesitancy □ Dysuria □ Urgency
□ Other symptoms _____

Endocrine

□ Polyuria (Frequent Urination) □ Polydysia (Excessive Thirst) □ Sexual Complaints
□ Heat intolerance □ Cold intolerance
□ Other symptoms _____

Musculoskeletal

□ Joint Pain □ Radiculopathy □ Fractures
□ Back Pain □ Joint Stiffness □ Sudden unexplained fractures
□ Other symptoms _____

Neurological

□ Ataxia □ Seizures □ Dizziness
□ Numbness □ Tingling □ Confusion
□ Speech Difficulties □ Motor Disturbances □ Sensory Disturbances
□ Other symptoms _____

Psychiatric

□ Anxiety □ Depression □ Panic Attacks
□ Suicidal Thoughts □ Suicide Attempts □ Sleep Disturbances
□ Mood Disorders □ Emotional Problems □ Depression Screening Completed
□ Other symptoms _____

Hematology / Immunology

□ Easy Bleeding tendency □ Easy Bruising tendency □ Swollen Nodes
□ Environmental Allergies □ Frequent Infections □ Food Allergy
□ Other symptoms _____