SOUTH TEXAS ORTHOPEDIC SPECIALISTS

PATIENT INFORMATION FORM

DATE: _____

Patient Name: _____

Mailing Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Patient SS#: _____ Date of Birth: _____ Sex: **M** or **F**

Martial Status: **S M D W** (*Circle One*) Student Status: **Part-time** or **Full-time**

Race: **White** **Black** **Asian** **Other** **Decline to Provide** (*Circle One*)

Emergency Contact:

Name: _____

GUARANTOR INFORMATION/RESPONSIBLE PARTY IF PATIENT IS A MINOR

Guarantor Name: _____

Relationship to Patient: _____

Guarantor SS#: _____ Guarantor DOB: _____

Mailing Address: _____

City _____ State _____ Zip _____

Cell Phone: _____ Work Phone: _____

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PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ lbs **Male** **Female**

Primary Care Doctor: _____ Cardiologist: _____

Did this injury occur while at work? **Yes** **No**

Is this auto accident related? **Yes** **No**

Do you have a lawyer for this injury?

If so, who? _____

Have you ever had an X-Ray or MRI? **Yes** **No**

If so, where? _____

Reason for your appointment today? _____

If injury- how/when did problems begin? _____

Which side? **Right** **Left** **Both** Which is your dominant hand? **Right** **Left**

Have you seen a doctor for this problem? **Yes** **No**

If so, who? _____

Have you seen a pain management doctor for this problem? **Yes** **No**

If so, who? _____

Have you had any previous surgeries to this area? **Yes** **No**

If so, who did it? _____

Have you been treated for this area with: Circle all that apply

Physical Therapy **Chiropractor** **Acupuncture**

Cane/Walker **Massage** **Brace** **Joint Injection**

Current Symptoms: **Pain** **Swelling** **Loss of Motion** **Numbness/TIngling**

How do you rate your pain on a scale of 0-10? (10 being worst): _____

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PATIENT HISTORY

Do you have any of these allergies? **Metal** **Latex** **Iodine** Other: _____

List any medication allergies: _____

Pharmacy Preference (no mail order): _____

Pharmacy Location: _____

LIST OF CURRENT MEDICATIONS (PRESCRIBED AND OTC)

MEDICATION (BRAND AND GENERIC NAME)	DOSE	HOW OFTEN DO YOU TAKE THE MEDICATION	REASON FOR TAKING MEDICATION	PRESCRIBER

Date Updated: _____

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FAMILY MEDICAL HISTORY

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
FATHER			
MOTHER			
SIBLING			
SIBLING			
SIBLING			
CHILD			
CHILD			
CHILD			

SOCIAL HISTORY

Smoking Status:

- ☐ Current casual smoker
- ☐ Current everyday smoker
- ☐ Former smoker
- ☐ Never smoked

Tobacco Use:

- ☐ 1-9 cigarettes per day
- ☐ 10-19 cigarettes per day
- ☐ 20-39 cigarettes per day
- ☐ 40+ cigarettes per day
- ☐ Cigar smoker
- ☐ Pipe smoker
- ☐ Smokeless tobacco

Alcohol Use:

- ☐ Yes
- ☐ No
- ☐ Social
- ☐ Occasionally

Quantity?_____ Kind?_____

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SOCIAL HISTORY

Drugs:

☐ Yes ☐ No ☐ Occasionally

Excercise:

☐ Yes ☐ No ☐ Occasionally

Nutrition:

☐ Regular diet ☐ No restrictions ☐ Vegetarian ☐ Other

Lives With:

☐ Parents ☐ Sibling ☐ Alone ☐ Spouse

☐ Partner ☐ Roommate ☐ Children ☐ Other

Number in household: _____

Additional Comments:

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PAST MEDICAL HISTORY

Mark the circle and write the year:

- ○ AID/HIV _____
- ○ ANGINA _____
- ○ ARRYTHMIA (ATRIAL FIB) _____
- ○ ASTHMA _____
- ○ ARTHRITIS _____
- ○ RHEUMATOID _____
- ○ PSORIASIS _____
- ○ GOUT _____
- ○ BALANCE DIFFICULTY _____
- ○ BLOOD CLOTS _____
- ○ PULMONARY EMBOLISM _____
- ○ BLOOD TRANSFUSION _____
- ○ CANCER _____
  IF YES, _____
- ○ DIABETES _____
- ○ COPD _____
- ○ FIBROMYALGIA _____
- ○ HEADACHES _____
- ○ HEART ATTACK _____
- ○ MULTIPLE SCLEROSIS _____
- ○ CIRRHOSIS _____
- ○ COGNITIVE DISORDER _____
  IF YES, _____
- ○ HEART MURMUR _____
- ○ HEPATITIS _____
  IF YES, WHICH TYPE: A B C
- ○ HIGH BLOOD PRESSURE _____
- ○ HYPO OR HYPERTHYROID _____
- ○ INCONTINENCE BOWEL/BLADDER _____
- ○ LUPUS _____
- ○ OSTEOPOROSIS _____
- ○ PSYCHIATRIC DISORDERS _____
  IF YES, _____
- ○ SEIZURES _____
- ○ STROKE _____
- ○ TUBERCULOSIS _____
- ○ COGESTIVE HEART FAILURE _____
- ○ HIGH CHOLESTEROL _____
- ○ PSORIASIS _____
- ○ DEMENITA/ALZHEIMER'S _____
- ○ PARKINSON'S _____
- ○ KIDNEY DISEASE _____

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PATIENT SURGICAL HISTORY

Have you ever had complications from Anesthesia? **Yes** **No**

List all previous surgeries.

	PROCEDURE	YEAR	SURGEON
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Authorization for Disclosure of Protected Health Information

I authorize South Texas Orthopedic Specialists to disclose protected health information to the following person(s)

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Signature of Patient or Authorized Person _____

Authorization/Notice of Privacy Practice Acknowledgement

I, the undersigned, irrevocably assign and transfer benefits to South Texas Orthopedic Specialists. I authorized South Texas Orthopedic Specialists, to file claims on my behalf and I assign insurance benefits to South Texas Orthopedic Specialists. If I am self pay, I understand I will be responsible for all charges rendered by South Texas Orthopedic Specialists. I understand there will be a $35.00 returned check fee for all checks returned. I, understand South Texas Orthopedic Specialists may use and disclose my protected health information for purpose of treatment, research, payment and health care operations.

_____ Date _____

Signature of Patient of Authorized Person