Today's Date:

Orthopedic Associates of Dallas - Centennial

4401 Coit Road, Suite 203 Frisco, Texas 75035 Phone: (469) 800-7070 Fax: (469) 800-7080

New Orthopedic Surgery Patient Medical History Form

Patient Name: **DOB:**

Name of Primary Care Physician:	Are you right or left handed?
What is your occupation?	
What pharmacy do you use:	
List your medications here: (please include strength and dosage)	
Please list all allergies here:	
Problem History Background	
What is your main complaint?	What is the date of your injury? How long has this complaint been present? years: months:
Please indicate your current pain level 0 1 2 3 4 5 6 7 8 9 10	What makes your pain **better**? Rest Heat Cold Medication Exercise Other _____
What words best describe how the pain feels? Sharp Burning Shooting Deep Stabbing Throbbing Aching Pressure Dull Tingling Other _____	What makes your pain **worse**? Rest Heat Cold Medication Exercise Other _____

Treatment History:

Have you been treated by another physician for this problem? YES NO

If yes, who? _____

Have you had surgery intended to treat your current complaint? YES NO

If yes, what type of surgery? _____

Have you had X-rays, MRI, CT scan or other radiologic imaging for this problem? YES NO

If yes, what type of testing? _____

Have you had an Electromyography or EMG/NCV test to evaluate nerve function? YES NO

If yes, who performed? _____

Have you tried activity modification? YES NO

If yes, what did you modify? _____

Have you tried NSAIDS? YES NO

If yes, what have you tried? _____

Have you gone to Physical Therapy for the complaint? YES NO

If yes, which facility did you go to? _____

Have you had any injections for this complaint? YES NO

If yes, what type of injections did you have? _____

Medical History:

Have you been diagnosed with any of the following conditions at any point in your life? (Please Circle)

AIDS/HIV	Coronary Artery Disease	Hypertension	Peptic Ulcer Disease
Alcoholism	Crohn's Disease	Inflamatory bowel diseae	Psoriasis
Alzheimers	Degenerative Joint Disease	Juvenile Rhermatiod Arthritis	PVD
Anemia	Depression	Kidney Disease	Renal Disease
Angina	Diabetes	Liver Disease	Rheumatiod Arthritis
Arthritis	Drug Abuse	Lyme Disease	Scoliosis
Asthma	DVT	Migraine Headaches	Seizure Disorder
Atrial Fibrilation	Fibromyalgia	Multiple Sclerosis	Sleep Apnea
Enlarged Prostate	Gallbladder Disease	Myocardial Infarction	SLE
Cancer	GERD	Obesity	Spinal Stenosis
Cerebrovascular incident	GOUT	Osteoarthritis	Spondylarthropathy
Congestive Heart Failure	Hepatitis	Osteoporosis	Thyriod Disease
COPD	Hyperlidemia	Parkinson Disease	Vavular Disease

Surgical History: Please list any previous surgeries and dates of service

ACL surgery:	Arthoscopy - ankle:	Gastric bypass:	ORIF:
Angioplasty:	Back Surgery:	Hernia repair:	Pacemaker:
Angio w/ stent:	CABG:	Hip arthoplasty:	Small bowel resection:
Appendecotmy:	Cardiac valve replacement:	Hip replacement:	Thyroidectomy:
Arthoscopy - shoulder:	Carpal tunnel relase:	Knee replacement:	Tonsillectomy:
Arthoscopy - elbow:	Cataract extraction:	Laminectomy:	
Arthroscopy - wrist:	Cholecystecomy:	LASIK:	OTHER:
Arthroscopy - hip:	Colostomy:	Meniscus surgery:	
Arthoscopy - knee:	Disectomy:	Muscle biopsy:	

Family History: Please list medical problems of your immediate family (i.e diabetes, high blood pressure, heart disease, etc.)

Relation	Medical Conditions

Review of Symptoms: Do you have any of the following symptoms today? (Please circle)

Constitutional
Chills
Diaphroesis (Excessive sweating)
Fatigue/Malaise
Weakness
Weight Loss

Eyes
Eye Discharge
Eye Pain
Eye Redness
Burred Vision
Double Vision
Photophobia (Sensitivity to light)

Psychiatric
Anxious/Nervous
Depression
Hallucinations
Insomnia
Memory Loss
Suicidal Ideas
Substance Abuse

Head & Neck
Ear Discharge
Ear Pain
Hearing Loss
Tinnitus (Ringing in ears)
Congestion
Nosebleeds
Sinus Pain
Sore Throat

Endocrine/Allergy/Heme
Polydipsia (Excessive thirst)
Environmental Allergies
Easy Bruising/Bleeding

Musculoskeletal
Arthralgias (Joint pain)
Back Pain
Joint Swelling
Myalgias (Muscle pain)
Neck Pain
Falls

Respiratory
Cough
Dyspnea (Shortness of breath)
Hemoptysis (Coughing up blood)
Sputum (Excessive mucus)
Wheezing

Cardiovascular
Chest Pain
Orthopnea
Palpitations
Proximal Nocturnal Dyspnea
Claudication
Lower Extremity Edema

Neurological
Dizziness
Focal Weakness
Headaches
Nubneess/Tingling
Seizures
Speech Change
Syncope (Loss of conciousness)
Tremors

Gastrointestinal
Abdominal Pain
Heartburn
Nausea
Vomitting
Consitpation
Diarrhea
Blood in Stool
Melena (Dark, sticky stool)

Skin
Itching
Rash

Genitourinary
Dysuria (Painful urination)
Flank Pain
Frequency
Hematuria (Blood in urine)
Urgency

I attest that everything stated here is true to the best of my knowledge:

Patient Signature: _____ Date: _____

I have personally reviewed this form with the patient:

Provider Signature: _____ Date: _____

Race, Ethnicity & Language

Acct #

HealthTexas Provider Network is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Race

Which category best describes your race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Some Other Race
- ☐ Unknown
- ☐ Patient Declined

Race Definitions: **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White or Caucasian:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Ethnicity

Which category best describes your ethnicity?

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Patient Declined

Language

What language do you feel most comfortable speaking with your doctor or nurse?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Chinese
- ☐ Dutch
- ☐ Hindi
- ☐ Other_____

_____ _____

Patient Name (please print) **Date**

BAYLOR SCOTT & WHITE HEALTH
PERMISSION FOR VERBAL COMMUNICATION

Patient Name _____ Date of Birth _____ Phone Number(s) _____

Full Address (City, State, and Zip Code) _____

I permit Baylor Scott & White Health to discuss my personal medical health information, in person and/or by telephone, with the following persons involved in my medical care for the following purposes:

- **To orally schedule or confirm my appointments;**
- **To discuss my care including the results of diagnostic tests, diagnosis, prognosis, and treatment plans that may include mental health records, psychotherapy notes, AIDS/HIV test results, substance abuse treatment records, blood bank records, and/or genetic information; or**
- **To discuss billing and payment for medical services.**

I understand that this document applies to all departments, healthcare providers and/or employees with Baylor Scott & White Health. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

	Name	**Relationship**	**Phone Number**
1.			
2.			
3.			

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to Baylor Scott & White Health – Office of Corporate Compliance, 2401 S. 31st Street, MS-AR-300, Temple, Texas 76508.

This document of Permission for Verbal Communication will expire upon revocation, or at the date or event specified here _____ .

This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at Baylor Scott & White Health.

_____ _____
Signature of Patient or Legal Representative (electronic signatures not acceptable) Date

_____ _____
Print Name of Patient or Legal Representative Relationship to Patient

_____
Representative's Authority to Act for Patient
(attach supporting documentation)

Authorization for Release of Information (To HTPN)

Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

I hereby authorize _____ _____
Entity or Person **from** whom records are requested Address

_____ _____ _____ _____ _____
Telephone Fax City State Zip

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____ _____ _____
Patient Name (please print) Date of Birth Social Security Number

_____ _____
Patient Address (City, State and Zip) Phone Number

_____ ☐ All Dates of Service
Specific Date(s) of Service (if known)

Information to be released: (Check all that apply)

☐ **Complete Medical Records** ☐ Radiology Reports & Films ☐ Registration Records ☐ Billing Records
☐ Visits & Encounters ☐ Laboratory Reports ☐ Consultation Reports ☐ Emergency Room
☐ Laboratory Reports ☐ Operative Records ☐ Other: _____

_____
Description of the purpose of the use and/or disclosure:

The health information described herein shall be **released to**:

Category: ☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other_____

_____ _____
Name of Person or Entity (please print) Phone Number

_____ _____
Address (City, State, and Zip) Fax Number

Delivery Method: ☐ Mailing Address ☐ Fax ☐ Pick-Up Records ☐ Other_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

_____
Printed Name of Patient, Parent, or Legal Guardian

_____ _____
Relationship to Patient **or** **Legal Authority** (Attach Supporting Documentation)