

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: <input type="checkbox"/> Diet controlled <input type="checkbox"/> Oral medications <input type="checkbox"/> Insulin <i>circle one</i> 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

Patient Name _____

D.O.B. _____

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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 Orthopaedic Associates, 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	
<input type="checkbox"/> Home Phone _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/> Cell Phone _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/> Work Phone _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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: _____

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