Somerset Orthopedics & Sports Medicine

Patient Health History

Date: _____

Name _____

Date of Birth: _____

Today's Chief Complaint: _____

Doctor to Notify: _____ Referred By: _____

How did you learn about our practice? Online Mail Friend Other:_____

Past Medical History: (please circle all that apply)

High Blood Pressure	Strokes	Diabetes	Blood Clots
Angina	Vascular Disease	Seizures	Asthma
Palpitations	Gout	Bleeding Problems	Emphysema

Other: _____

Past Surgical History: (please circle all that apply – indicate the year the procedure was performed)

Stents/Pacemaker: _____

Total Joint Replacements: _____

Knee Surgery: _____

Shoulder Surgery: _____

Spine Surgery: _____

Other: _____

_____

Social History:

Tobacco Use – Yes/No/Former: ____packs/day Quit_____years ago and smoked _____packs/day

Alcohol Use – Daily/Occasional/None Drug Use – Never/Current/Past: type _____

Occupation: _____

Review of Systems: (please circle all that apply)					
Eyes:	Double Vision	Blurring	Glasses	Others:	
ENT (ears/nose/throat):	Loss of Hearing	Hearing Aid	Sinsusitis	Hoarseness	Vertigo
Heart:	Chest Pains	Palpitations	High Blood Pressure	Others:	
Lungs:	Asthma	Shortness of Breath	Cough	Emphysema	COPD
GI:	Stomach	Bowels	Diarrhea	Constipation	Weight Loss	Appetite
GU:	Kidneys	Bladder	Incontinence	Painful Urination	
MSK:	Muscles	Joints			
Skin:	Rashes Ulcers	Masses	Scars		
Neurological:	Coordination	Weakness	Visual Changes	Changes in Sensation	Balance
Psychiatric:	Depression	Sleep Disturbances	Mood Swings	Hallucinations	
Endocrine:	Growth Changes	Hair Changes	Hyperactivity	Hypoactivity	
Hem/Lymph:	Bleeding	Anemia	Lymph Node Swelling		

For Office Use Only:

Reviewed By: _____Signature_____

Somerset Orthopedics & Sports Medicine

Patient Name _____ Age_____ Date_____

Please select from the following:

( ) Work Injury ( ) Auto Accident ( ) No Apparent Reason ( ) Other

Dominant Hand: Left Right **History:**

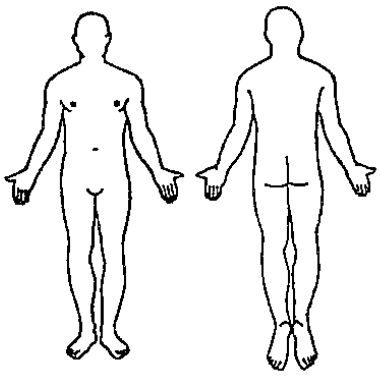
Location of Pain:

( )Left ( )Right ( )Both
( )Back ( )Buttock ( )Groin
( )Calf ( )Foot ( )Neck
( )Shoulder ( )Arm ( )Hand
( )Anterior Thigh ( )Posterior Thigh
( )Knee ( ) Other_____

Is Condition: ( )Improving ( )Unchanged
( )Worsened

Percentage of Pain: (if applicable)

Back _____ Leg _____
Neck _____ Arm _____ Total = 100%



Mark all areas with an:
X - where you experience pain
O - where you experience numbness

Rate pain on a scale of 0 -10:

(0 = no pain, 10 = most severe pain imaginable)

Back _____ Buttock _____ Groin_____ Thigh_____
Neck _____ Shoulder_____ Calf_____ Foot _____
Arm _____ Hand _____ Knee _____ Elbow _____

What makes symptoms worse?

( ) Bending ( ) Sitting ( ) Rising ( ) Standing
( )Walking ( ) Lying ( ) Stationary ( ) On the Move
( ) A.M. ( ) As the day progresses ( ) P.M. ( ) Driving
( ) Up/Down the Stairs
( ) Other _____
_____

What makes symptoms better?

( ) Bending ( ) Sitting ( ) Rising ( ) Standing
( )Walking ( ) Lying ( ) Stationary ( ) On the Move
( ) Other _____
_____

Do you experience pain at night? ( ) Yes ( ) No
Does coughing, sneezing, or straining increase pain? ( ) Yes ( ) No
Do you experience loss of bowel/bladder control? ( ) Yes ( ) No
Do you experience: ( ) dizziness ( ) Nausea ( ) Headache ( ) Ringing in ears
How long can you: walk_____ stand _____ sit _____ drive _____
Any previous back/neck history? _____
_____
_____
Any recent surgery? _____
If yes, please indicate the type and surgery date: _____
_____
Have you experienced a recent weight loss? How much? _____

Somerset Orthopedics & Sports Medicine

Name: _____ Date: _____

Height: _____ Weight: _____

Please list all allergies:

Are you currently on any blood thinning medications? Yes No

**Please indicate the medication and dosage: _____

**Pharmacy Name and Phone Number: _____

_____

Please list all current medications:

Medication	Dosage	Frequency

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Patient Registration

Name _____ Social Security #_____ DOB _____

Address _____ Home Phone _____ Cell Phone_____

_____ Work Phone _____ Email _____

_____ Referring Dr _____ Employer _____

Ethnicity: Hispanic or Latino ___YES ___ NO Employer Address _____

Race: American Indian or Alaska Native, Asian, Black or African American ,Native Hawaiian, White , Other_____

Primary Language Spoken _____ How did you hear about our Practice? _____

Do you have any allergies? If so please list all _____

Is your visit due to an injury at work?	___Yes	___No
Do you have an active Worker's Compensation Claim?	___Yes	___No
Is your visit due to a motor vehicle accident?	___Yes	___No
Are you a resident in a skilled nursing facility?	___Yes	___No
Was this a sports/school/league injury?	___Yes	___No

RESPONSIBLE PARTY

Name _____ Relationship to patient _____

Social Security #_____ DOB _____ Employer _____

Address _____ Work Phone _____

_____ Home Phone _____ Cell _____

Name _____ Relationship to Patient _____

Home Phone_____ Cell _____ Work Phone _____

Primary Insurance _____ Effective Date _____

ID _____ Policy Owner/Subscriber _____

Group # _____ Social Security # _____

Group Name _____ Subscriber DOB _____

Co –Payment _____ Relationship to Patient _____

Secondary Insurance _____Effective Date _____

ID _____ Policy Owner/Subscriber _____

Group # _____ Social Security # _____

Group Name _____ Subscriber DOB _____

Co –Payment _____ Relationship to Patient _____

ASSIGNMENT OF MEDICAL BENEFITS and AUTHORIZATION TO RELEASE INFORMATION

I authorize Somerset Orthopedics & Sports Medicine to release any medical information necessary to process insurance claims relating to the medical care provided by its doctors and/or associates. I also authorize release of medical information to my primary referring physician. I authorize payment of medical benefits to Somerset Orthopedics & Sports Medicine for any medical care provided to me or to my dependent(s). I understand that I will be responsible for any charges not covered by my insurance carrier(s). Should enforcement be necessary for the collection of the bill, a $50 fee for account balances up to $99.99 and $100 will be added to the bill.

By my signature, I verify that the information on this form is true and correct as of the date indicated below.

Signature, Patient or Patient's Representative _____ Date _____

Somerset Orthopedics & Sports Medicine
1 Robertson Drive – Suite 24
Bedminster, NJ, 07921

I, _____ (Patient Name) acknowledge receipt of the above organization's Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

-OFFICE USE ONLY-

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: _____

_____

Signature of Covered Entity Representative: _____

Printed Names: _____ Date: _____