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:**

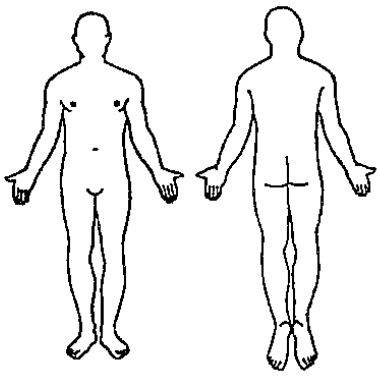
**Location of Pain:**

( )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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# Somerset Orthopedics & Sports Medicine

## Medicare Patient Registration/ Signature of File

Federally mandated HIPPA regulations require us to obtain this information from you for billing your insurance company.
**PLEASE COMPLETE ALL AREAS OF THIS FORM**

Patient Name: _____ Male___ Female ____ DOB: _____

Address: _____ Marital Status: S M W D (Please circle one)

City: _____ Apt/Rm# _____ Zip: _____

Home Phone: _____ Cell Phone: _____ SS#: _____

Are you currently employed? Yes ___ No ____

May we contact you by email? If yes, please give us your email address: _____

Tell us how you were referred to this practice: _____

Emergency Contact: _____ Phone: _____

Responsible Party: _____ Phone: _____

(Parent or Guardian)

ANY ALLERGIES? _____ (continue on back of sheet if necessary)

Referring Doctor
Name: _____

Address: _____

City: _____

State: _____ Zip: _____

WORK RELATED INJURY? ___YES ___NO

MOTOR VEHICLE RELATED INJURY? ___YES ___NO

(You will be required to complete more paperwork if your response is "Yes" to either question)

Medicare ID Number: _____

Insurance Company Name: _____
(PLEASE INDICATE INSURANCE CO NAME AND ADDRESS IF OTHER THAN TRADITIONAL MEDICARE)

Secondary Insurance (if applicable)

Subscriber Name: _____ DOB: _____ (if other than the patient)

Secondary Insurance Co. Name: _____

Address: _____

ID Number: _____ Group #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Somerset Orthopedics & Sports Medicine/ New Jersey Spine Institute, P.A. or the insurance company to release any information required to process my claims and I authorize the release of my records to my referring/primary care physician. I understand that upon signing this form, I am responsible for payment of the medical services rendered by the physician(s). Should enforcement be necessary for the collection of the bill, a $50.00 fee for accounts up to $99.99 and $100.00 fee for accounts over $100.00 will be added to the bill.

Signature: _____ Date: _____
Signed by Patient or Parent/Guardian is a minor

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: _____