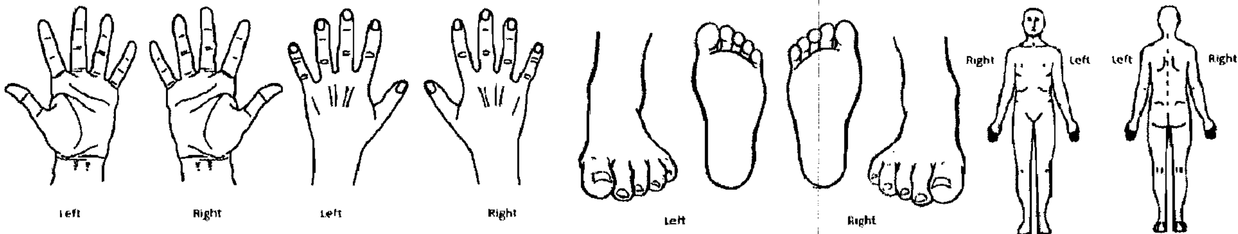
EmergeOrtho Comprehensive History Questionnaire

Name: ______________________ Date: ____________

Name of Referring Physician: ______________________ Age: ____________
Name of Family Physician: ______________________ Height: ____________
Place of Employment: ______________________ Weight: ____________
Occupation: ______________________ BP: ____________
Preferred Pharmacy: ______________________ Pulse: ____________

Chief Complaint / Current Problem: ______________________

History of Present Illness: (answer based on what you are being seen for today)
Please indicate on the picture where your problem is with an "**X**"



What symptoms are you experiencing? ______________________

How long have you had this problem? ______________________
Have you had a similar pain in the past? ______________________
☐ yes ☐ no If yes, when? ______________________
How did your current problem happen? ______________________
Injury? ☐ yes ☐ no If yes, give date of injury ______________________
Where did it occur?
Work related? ☐ yes ☐ no
How many work days have you missed? ______________________
Are you working now? ☐ yes ☐ no ______________________
Have you had previous work-related injuries? ______________________
How severe is this for you? (place an "X" on the line below
No Pain (0) -- (10) Worst pain of my life
What makes it worse? (sitting, standing, walking, exercise, coughing/sneezing) ______________________

What makes it better? (Lying, sitting, standing, walking, exercise, pain pills) ______________________
Give previous treatment for this problem: (Emergency Room, Physical Therapy, Chiropractor, or Other Treatment)

____

Have you had any of the following diagnostic studies for your current problem?

Type	Location of Study	Date of Study
X-Rays		
MRI / CT scan		
Ultrasound		
Myelogram		
Epidural Steroid Injection / Facet Joint Block		
EMG / NCV		

Allergies to Medications? **None** ☐

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Other Allergies? (non-medications) **None** ☐

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Please list any Metal allergies **None** ☐

____

List Current Medications (name, dose, frequency) **None** ☐

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

Are you in Pain Management? ☐ yes ☐ no with what MD? ______________

Family Medical History:	Father	Mother	Brother	Sister
Cancer:				
Diabetes:				
Heart Disease:				
High Blood Pressure:				
Stroke:				
Other: __________				

Tobacco History:

☐ Never smoker
☐ Current smoker ☐ Every day
☐ Smokeless tobacco ☐ e-cigarettes
☐ Former smoker
☐ Some days

years? ________
How much ? ________
Year started? ________

Social History:

☐ Single ☐ Married ☐ Widowed ☐ Divorced / Separated ☐ Partner
☐ Alcohol use (drinks per day) ________

Past Surgical History: (list prior surgeries, especially those related to your current problem)

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Past Medical History

Please indicate if you have ever had any of the following conditions:

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Clot
- ☐ Cancer
- ☐ Claustrophobia
- ☐ Colitis / Stomach Ulcer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Dependency / Abuse
- ☐ Emphysema / COPD
- ☐ Eye Disease / Cataracts / Glaucoma
- ☐ Fibromyalgia
- ☐ GERD / Reflux
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Liver Disease
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Hypertension
- ☐ Joint Pain
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung Disease
- ☐ Lupus / SLE
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psoriasis
- ☐ Seizures / Epilepsy
- ☐ Sleep Apnea
- ☐ Stroke / TIA
- ☐ Swelling of Legs / Feet / Hands
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Weight Changes

Other: ____

____

Are you CURRENTLY being treated for or experiencing any of the following:

GENERAL:
- ☐ Fever / Chills
- ☐ Weight Loss

HEENT:
- ☐ Vision Change
- ☐ Sore Throat

CARDIOVASCULAR:
- ☐ Chest Pain
- ☐ Poor Circulation
- ☐ Swelling of legs
- ☐ Palpitation

RESPIRATORY:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ COPD

GASTROINTESTINAL:
- ☐ Black Tarry Stools
- ☐ Bloody Stool
- ☐ Diarrhea
- ☐ Vomiting

GENITOURINARY:
- ☐ Blood in Urine
- ☐ Difficulty Urinating

MUSCULOSKELETAL:
- ☐ Joint Pain
- ☐ Joint Swelling

SKIN:
- ☐ Rash
- ☐ Varicose Veins
- ☐ Leg / Foot Ulcers

NEUROLOGICAL:
- ☐ Dizziness
- ☐ Numbness
- ☐ Difficulty with Balance
- ☐ Seizures

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression

ENDOCRINE:
- ☐ Heat Intolerance
- ☐ Thyroid Disease
- ☐ Diabetes

HEMATOLOGICAL:
- ☐ Anemia
- ☐ Bleed/Bruise Easily
- ☐ Swollen Glands

Other: ____

____

This document was reviewed on the above date by: ______________________ **MD.**

Consent to Use OR Disclose Information For Treatment, Payment or Health Care Operations

The patient or legally authorized guardian hereby consents to the use of his/her individually identifiable health information ("protected health information") by EmergeOrtho in order to carry out treatment, payment or health care operations. The patient should review EmergeOrtho Notice of Privacy Practices for Protected Health Information (Notice) for a more complete description of the potential uses and disclosures of such information. The patient has the right to review such Notice Prior to signing the consent form.

EmergeOrtho reserves the right to change the terms of Notice of Privacy Practices for Protected Health Information (Notice) at any time. If EmergeOrtho does change the terms of its Notice, the patient may obtain a copy of the revised Notice.

Patients retain the right to request that EmergeOrtho further restrict how his/her protected health information is used or disclosed to carry our treatment, payment, or health care operations, EmergeOrtho is not required to agree to such requested restrictions; however, if EmergeOrtho does agree to Patient's requested reaction(s), such reactions are then binding on EmergeOrtho.

EmergeOrtho may communicate electronically to a patient as long as our organization provides reasonable safeguards. Our office makes every attempt to protect a patient's Private Healthcare Information (PHI). Patients have the right to initiate communication via electronic messaging to your healthcare provider. However, external email communication is not encrypted. If you prefer additional safeguards or encrypted messaging, please use EmergeOrtho's portal, https://847.portal.athenahealth.com/ through fax or via phone call to the office.

The patient retains the right to revoke this Consent. At all times such revocation must be submitted to EmergeOrtho in writing. The revocation shall be effective except to the extent that EmergeOrtho has already taken action in reliance on the Consent.

EmergeOrtho may refuse to treat patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that EmergeOrtho is required by law to treat individuals). If patient (or authorized representative) signs this consent form and then revokes Consent, EmergeOrtho has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that EmergeOrtho is required by law to treat individual).
I authorize release of my medical information to the following companies, individuals and/or school system:

Name	Relationship	Telephone number
Name	Relationship	Telephone number
Name	Relationship	Telephone number
School	Athletic Trainer/Coach	Telephone number

Additionally, I consent to treatment necessary for the care of the below named person for whom I am legally responsible. I authorize the release of all medical records to the referring or primary care physicians, or to other physicians as required for treatment and to my health insurance company, if applicable. Lastly, I acknowledge my consent to release Medical Records and/or information to my dependents/child's school, athletic trainer and/or coach in an effort to coordinate sports or physical activity. I authorize transmission of medical information by fax. I authorize my health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I also acknowledge full financial responsibility for services rendered by EmergeOrtho.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY AD I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

I authorize the release of medical information to insurance carriers and authorize insurance payment directly to EmergeOrtho. I also understand that my physician may need access to my medication history and may work in conjunction with my pharmacy and/or insurance carrier in order to provide accurate medical treatment. I am responsible for all of my co-pay charges and those charges denied or determined non-covered by my insurance.

PATIENT'S DOB______________________________ PRINTED NAME____

LEGAL GUARDIAN____________________________ SIGNATURE & DATE ____________________________________

☐

Please indicate by initialing the box that you authorize EmergeOrtho to communicate with you via e-mail and also with, third parties, such as, physicians, nurse case managers, insurance companies and adjusters and employers. E-mail cannot be guaranteed to be a secure or error free transmission, as information could be intercepted, corrupted, lost, destroyed.