THE HIP & KNEE CENTER

Date

MEDICAL HISTORY FORM

PATIENT INFORMATION

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

Age **Date of Birth** **Right or Left handed?** ◯ Right ◯ Left

Working Status ◯ Working ◯ Retired ◯ Disabled

Occupation

PHYSICIANS

Referring Physician *(First) (Last)* **Telephone**

Primary Care Physician *(First) (Last)* **Telephone**

PREFERRED PHARMACY

Name, Address **Telephone**

MEDICAL INFORMATION

Chief Complaint *(Example: Right hip pain)*

Date of injury or onset of symptoms

Describe your symptoms *(Example: a sharp pain when I walk)*

How did the injury happen?

Symptom Relief *(Example: rest, heat/cold, therapy, medication)*

Symptom Aggravation *(Example: activity, movement)*

Additional Symptoms

Describe Treatment

Have you had any diagnostic tests for this problem? ◯ Yes ◯ No **If Yes, what & where?**

Has a physician recommended that you have surgery for this problem? ◯ Yes ◯ No

Name of previous treating physician(s), if any?

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY *(Please list the surgical procedure, date of procedure and complications)*

Have you ever had problems with anesthesia? ◯ Yes ◯ No

If yes, describe:

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SOCIAL HISTORY

Student? ◯ Yes ◯ No

School _____ **Grade** _____

Sport _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you live alone? ☐ Yes ☐ No

Alcohol use ☐ Never ☐ Occasional ☐ Daily ☐ Heavy

History of alcoholism? ☐ Yes ☐ No

History of drug use? ☐ Yes ☐ No

FAMILY HISTORY

MEDICATIONS

Medication Name	Dosage	Medication Name	Dosage

Are you taking low-dose Aspirin? ☐ Yes ☐ No

Are you taking Anti-coagulants? ☐ Yes ☐ No

Are you taking Corticosteroids? ☐ Yes ☐ No

Have you taken at least two different anti-inflammatory medications for your condition? ◯ Yes ◯ No

If Yes, how long? _____

ALLERGIES (*Please list type of allergy (medications, latex, metals, etc) and type of reaction you experience)*

RISK FACTORS

Tobacco use ◯ Never Smoked ◯ Former Smoker **Are you a current smoker?** ☐ Yes ☐ No

Height _____ **Weight** _____ **BP** _____ \ _____

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REVIEW of SYSTEMS *(Have or do you ever experience any of the following signs or symptoms? If yes please describe)*

Sign/Symptom	Yes/No	Describe all "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)	◯ Yes ◯ No	
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	◯ Yes ◯ No	
Cardiovascular (e.g. chest pain, palpitations)	◯ Yes ◯ No	
Respiratory (e.g. shortness of breath, cough, snore)	◯ Yes ◯ No	
Gastrointestinal (e.g. ulcer, gastritis, GI bleed)	◯ Yes ◯ No	
Genitourinary (e.g. burning, bleeding)	◯ Yes ◯ No	
Musculoskeletal (e.g. joint, muscle, back or neck pain)	◯ Yes ◯ No	
Skin (e.g. delayed healing, rash, acne, cellulitis)	◯ Yes ◯ No	
Neurological (e.g. numbness, tingling, weakness)	◯ Yes ◯ No	
Endocrine (e.g. weight gain/loss, excess thirst or urine)	◯ Yes ◯ No	
Hematologic (e.g. bruising, bleeding, clotting disorder)	◯ Yes ◯ No	
Allergic / Immunologic (e.g. rash, swelling, wheezing)	◯ Yes ◯ No	

COMMENTS OR CLARIFICATION

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

Patient Signature **Signed Date**

Guardian Signature **Signed Date**

Guardian/Authorized Representative *(Name)*

Provider Statement:

I have reviewed the questionnaire with the patient.

Any Changes?

◯ Yes ◯ No **Signed** **Date**

◯ Yes ◯ No **Signed** **Date**

◯ Yes ◯ No **Signed** **Date**

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Account # _____

PATIENT INFORMATION

Name *(First) (Middle) (Last)* _____ ◯ Male ◯ Female

Age _____ **Date of Birth** _____

SSN _____ **Marital Status** ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Telephone _____ **Work Telephone** _____ **Cell Telephone** _____

Email _____ **Can we email you newsletters?** ◯ Yes ◯ No

Preferred Language _____ **Ethnicity** ☐ Hispanic ☐ Non-Hispanic **Race** _____

PHYSICIANS

Referring Physician *(First) (Last)* _____ **Telephone** _____

Primary Care Physician *(First) (Last)* _____ **Telephone** _____

GUARANTOR

☐ Guarantor Same As Patient **Relationship** _____ **Telephone** _____ **Date of Birth** _____

Name *(First) (Middle) (Last)* _____ ◯ Male ◯ Female

SSN _____ **Occupation** _____ **Employer** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

PATIENT EMPLOYMENT AND EMERGENCY CONTACT

Employment Status ◯ Working ◯ Retired ◯ Disabled **Emergency Contact** _____

Occupation _____ **Telephone** _____

Employer _____ **Relationship** _____

INSURANCE CARRIERS

	Carrier #1	Carrier #2
Name		
Policy/Claim #		
Group ID		
Policy Holder		
Policy Holder DOB		

Work Related? ◯ Yes ◯ No

Work Comp Insurance _____ **Work Comp Contact** _____

Insurance Address **Contact Telephone** _____

Claim # _____

Insurance Telephone _____

I hereby authorize The Hip and Knee Center to release any information to my insurance company acquired in the course of my examination or treatment. I hereby authorize bene! ts to be paid directly to them. I authorize them to check pharmacies for my prescription history. I understand I am responsible for any unpaid balance.

Sign *(Parent if Patient is a minor)* _____ **Date** _____