Hamilton Orthopedic Surgery & Sports Medicine

Name:_____ Date of Birth_____

Ht:_____ Wt:_____ BP:_____ P:_____ R:_____

Who is your primary care doctor?:_____Who referred you to us?:_____

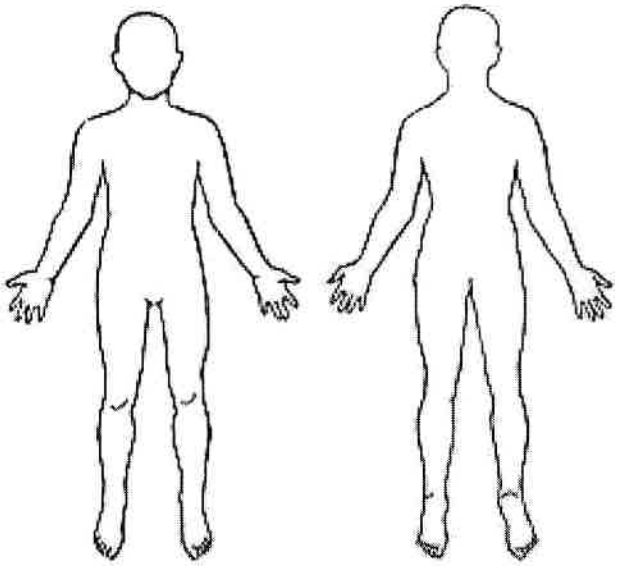
How long have you had the pain?_____

Was this a result of an injury? (circle one) **Yes or No** If so, what was the date of the injury?:_____

If so, is this a workman's compensation injury (circle one) **Yes or No** or no fault? (circle one) **Yes or No**

Are you currently working? **Yes or No** **Employer:** _____ **Job Title:** _____

Dominant Hand: **LEFT** or **RIGHT**



Pain Scale

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Have you had any of the following treatments? (Please circle)

NSAID -- Year_____
Was it helpful?

Physical Therapy – Year _____
Was it helpful?

Chiropractor -- Year_____
Was it helpful?

Injections -- Year_____
Was it helpful?

Acupuncture – Year_____
Was it helpful?

Massage - Year_____
Was it helpful?

Surgery – Year _____
Was it helpful?

Do you have pain with...		Are you better with...		Have you had any of the following?	
	Lifting		Lifting		X-rays
	Bending		Bending		MRI
	Sitting		Sitting		CT Scan
	Walking		Walking		CT Myelogram
	Laying down		Lying down		Bone Scan
	Activity in general		Activity in general		EMG
	Nothing in particular		Nothing in particular		Stress Echo
	Stairs				

Are you allergic to any medications? (circle one) **Yes or No**

If so, please list:_____

Are you allergic to contrast dye of iodine? (circle one) **Yes or No**

Please write in *date* (month & year) and if not done, write "n/a" for the following: Covid vaccine: _____

Most recent Flu Shot: _____ Pneumonia shot:_____ Hepatitis B shots:_____

Female: Physical: _____ Pap Smear/Rectal: _____ Breast Exam: _____ Mammo: _____

Colonoscopy: _____

Male: Physical: _____ Prostate/Rectal:_____ Colonoscopy: _____

NAME:_____ Date of Birth_____

Review Of Systems

Place a check in the box if you have any of these symptoms:

	Fever or Chills		Chest Pain		Blood in Stool
	Weight Loss		Heart Palpations		Change in Bowel Habits
	Double Vision		Shortness of Breath		Urinary Urgency
	Blurred Vison		Skin Issues		Urinary Incontinence
	Changes in hearing		Rashes		Blood in Urine
	Nose Bleeds		Intolerance to Heat		Depression
	Coughing up Blood		Intolerance to Cold		Anxiety

Medical History

Place a check in the box if you have any of the following conditions:

	MRSA infections		COPD		Kidney Stones
	Hepatitis		Asthma		Kidney Disease
	DVT (blood clot)		Heart Attack		Meningitis
	Pulmonary Embolism		Heart Murmur		Epilepsy
	Alcoholism		High Blood Pressure		Headaches
	Arthritis		High Cholesterol		Seizures
	Bleeding Disorders		Rheumatic Fever		Stomach Ulcers
	Cancer		Diabetes		Gastric Reflux
	Stroke		Thyroid Disease		Tuberculosis
	Depression		Anxiety		Bipolar Disorder

Do you have a history of any other medical problems not listed above? (circle one) **Yes or No**

If so, please list:_____

Have you had any surgeries? (circle one) **Yes or No**

If so, please list:

Type of Surgery	Date of Surgery	Location of Hospital

Have you been hospitalized for any reason other than the above surgeries? (circle one) **Yes or No**

If so, please list:

Type of Illness	Date of Hospitalization	Location of Hospital

Have you ever required a blood transfusion? (circle one) **Yes or No**

If yes, please explain: _____

NAME:_____ Date of Birth_____

Family History

Please fill in the following table regarding the health of your parents, siblings, and children.

If you cannot answer the question, please write "don't know". If you do not have children/siblings, please write "n/a".

Health Problems DOB

Father:_____/_____

Mother:_____/_____

Your Children: How many total?:_____

Health Problems	DOB	Health Problems	DOB
Boys:_____	/_____	Girls: _____	/_____
_____	/_____	_____	/_____
_____	/_____	_____	/_____

Your Siblings: How many total?: _____

Health Problems	DOB	Health Problems	DOB
Brothers:_____	/_____	Sisters: _____	/_____
_____	/_____	_____	/_____
_____	/_____	_____	/_____

Social History

Are you married, single, divorced, or widowed? _____

Do you live alone (circle one) **Yes or No** If no, with whom do you live?_____

Are you presently employed? (circle one) **Yes or No** If no, why? _____

Do you exercise regularly? (circle one) **Yes or No**

Do you need assistive devices to walk? (circle one) **Yes or No** If yes, which one? **walker cane wheelchair**

Do you smoke cigarettes now? (circle one) **Yes or No**

Do you use other tobacco products? (circle one) **Yes or No**

If yes, how many packs a day do you smoke?_____

How many years have you smoked? _____

If you quit, how many packs a day did you smoke? ____

How many years did you smoke?____

Do you drink beer, wine, or liquor?____

If yes, how many do you drink per week?____

Do you use recreational drugs?_____

If yes, please explain:_____

Medications

Name of Medication	Strength (example 800mg)	Dosage & Time	Reason for Medication

PATIENT INFORMATION

Race: W AA Asian Other **Ethnicity:** Hisp/Lat Not Hisp/Lat Decline **Lang:** Eng, Span, Other:_____

First Name	Middle	Last	Birth Date	Age	Sex

Street Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	Social Security #

Employer	Employer Address
Next of Kin/Emergency Contact name	Relationship
Family Doctor	Referred By
What Pharmacy Do You Use?	Address

EMAIL ADDRESS: (Hamilton Orthopaedics Use Only-we do not share this information with anyone)

Insurance Subscriber Information

First Name	Middle	Last	Birth Date	Age	Sex

Street Address	City	State	Zip

Home Phone	Work Phone	Employer	Social Security #

Employer Address

Primary Insurance Company

Name	Policy ID No.	Group #

Street Address	City	State	Zip

Name of Policy Holder	Relationship to Insured

Secondary Insurance Company

Name	Policy ID No.	Group #

Street Address	City	State	Zip

Name of Policy Holder	Relationship to Insured

Financial Policy

I understand that I am ultimately responsible for the payment in full of all charges and have been instructed that copays and/or deductibles will be collected at the time of service. You may apply to "Care Credit" if necessary. All collection fees incurred due to an unpaid balance will be the responsibility of the patient or responsible party. We can offer more information if necessary. We reserve the right to deny access to our services if your account has a balance and you are not actively making reasonable payments.

Assignment of Insurance Benefits

I authorize payment of benefits from my insurance be paid, directly to the provider. I also authorize Hamilton Orthopaedics to release to my insurance company any and all information necessary for the processing of insurance claims.

Signature _____ Date _____