ANDREWS INSTITUTE
ORTHOPAEDICS & SPORTS MEDICINE

Chief Complaint Form: **Date:** _____

Patient Name: _____ _____
First MI Last Preferred Name

Age: _____ DOB: _____ Occupation: _____ Employer:_____

Send Note?
Referring Physician: _____ Town: _____ Y N

Primary Care Physician: _____ Town: _____ Y N

Coach/Trainer/Team Doctor: _____ School: _____ Y N

Body part being seen for: _____

Side of Body: (circle) Right Left Both

Date Symptoms Began: _____

Was there an injury? (circle) Yes No Workers Comp? (circle) Yes No

If so, how did it happen?

_____

_____

Current Symptoms: _____

If there is pain, where is it located? _____

Are your symptoms? (circle) Improving Worsening Stable

Are your symptoms? (circle) Mild Mild/Mod. Moderate Mod./Severe Severe

What activities or body positions make your symptoms worse?
(ex. Walking, running, reaching overhead)

_____

_____

Have you had prior treatment? (ex. Injections, surgery, physical therapy)

_____

_____

Medical History:

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type _____			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis – TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			OTHER: _____		

Please list any **operations/surgeries** you have had:

SURGERY/ REASON	YEAR	**SURGERY/REASON**	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any **Medications** that you are currently taking:

MEDICATION	DOSE	DOCTOR	**MEDICATION**	DOSE	DOCTOR
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Do you have any **allergies** to medications/substances? Yes No

_____

Family Medical History: Please list major illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	**MEDICAL ILLNESS**	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Social History:

Alcohol use: Yes No Drinks per week: _____

Cigarette use: Yes No Packs per day:____ Years: _____

Smokeless Tobacco use: Yes No Years: _____

Illicit Drug use: Yes No Type: _____

Review of Symptoms: Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	**SYMPTOM**	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

Notice of Privacy Practices: I am aware that Andrews Orthopaedic and Sports Medicine Center has a "Notice of Privacy Practices" in accordance with Baptist Health Care's privacy policies. I understand that a copy is available to me and I agree with these privacy policies.

x _____ Date: _____

How were you referred to our practice? (circle)

Friend/Relative: _____ Physician Newspaper Radio Healthsource

Other: _____

Patient Demographics:

Patient Name: _____ _____
First MI Last Preferred Name

SS#: _____ Birth date: _____ Sex: Male Female

Address: _____ _____ ____ _____
Street Address City State Zip

Home #: _____ Cell #: _____ Work#:_____

Marital Status: Married Single Divorced Widowed Date of Injury: _____

Race: African American American-Indian Asian Caucasian Hispanic Other

Guardian Information: (If Patient is a Minor)

Name: _____ Relationship to Patient: _____

SS#: _____ Birth date: _____ Sex: Male Female

Address: _____ _____ ____ _____
Street Address City State Zip

Home #: _____ Cell #: _____ Work#:_____

Payment Information:

Form of Payment: Health Insurance Auto Insurance Workers Comp Self Pay

Primary Insurance

Primary Company:_____ Insured's name:_____
Policy #:_____ Group #:_____ Insured's Date of Birth:_____

Secondary Insurance

Secondary Company:_____ Insured's name:_____
Policy #:_____ Insured's Date of Birth:_____

Self Pay Agreement

I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine Center. I understand that there are payment plans available at my request.

x _____ Date: _____

Release of Information: I authorize Andrews Orthopaedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third-party payers in order to assist in the payment of claims.

x _____ Date: _____