ANDREWS INSTITUTE
ORTHOPAEDICS & SPORTS MEDICINE
An Affiliate of Baptist Health Care

Andrews Institute Physical Medicine
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Dear Patient:

In anticipation of your upcoming appointment, we would appreciate your attention to the following information:

- Please complete the following paperwork in its entirety to ensure the most accurate records for our physicians. This includes an up-to-date medication list.

- You must be 15 minutes early with your completed paperwork so that we may verify your insurance, scan your cards, and build your chart in time for your appointment. Please make travel arrangements to be *early* to your appointment.

- If you are late to your appointment, we reserve the right to reschedule. This policy is per our providers to ensure a timely schedule for both the physician and our patients.

- **It is the patient's responsibility to verify that our office is In-Network with their insurance. Please call the "1-800" or Customer Care telephone number on the back of the insurance card as soon as possible to verify this information.**

- If you are to be treated for injuries sustained during a motor vehicle accident, bring your automobile insurance card as well as your health insurance cards.

- Please provide our office any pertinent X-ray, MRI or CT reports. This is immensely helpful to the productivity of your appointment.

- Please keep in mind that an appointment with our office is not a guarantee of narcotics or opiates - regardless if you are currently prescribed these medications by another physician.

Helpful tips for our patients:

- If your X-rays, MRIs, CTs or any other scans were completed in a Baptist Health Care facility - we will have access to those images and reports. You will not need to bring those items. Just kindly inform the front desk at check in, and we will get those items attached to your chart for you.

- If you have additional medical records that you find pertinent to your care in our office, please bring them with you. We will be glad to add them to your records. **"We are happy to schedule you as a new patient with Dr. Tan. Please be advised Dr. Tan will not prescribe narcotic medications on your first visit and he will evaluate you to determine if narcotic medications are appropriate during your appointment. We look forward to meeting you at your upcoming appointment. Thank you for choosing Andrews Institute Physical Medicine."**

ANDREWS INSTITUTE PHYSICAL MEDICINE

DEMOGRAPHICS

Please Print

PATIENT NAME _____

SS#_____BIRTH DATE_____SEX: MALE FEMALE

ADDRESS_____

CITY_____STATE____ ZIP: _____

HOME# _____CELL# _____WORK# _____

MARITAL STATUS: _____DATE OF INJURY IF APPLICABLE_____

EMAIL ADDRESS _____

EMERGENCY CONTACT INFORMATION:

NAME: _____NUMBER:_____RELATIONSHIP_____

GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

NAME_____RELATIONSHIP TO PATIENT: _____

SS# _____DATE OF BIRTH _____

ADDRESS: _____

HOME# _____CELL# _____

PATIENT INFORMATION:

HEALTH INSURANCE AUTO INSURANCE WORKERS COMP SELF PAY

PRIMARY INSURANCE

TYPE: _____INSURED'S NAME _____

INSURED'S DATE OF BIRTH _____

POLICY# _____ GROUP# _____

CLAIM# _____

ADJUSTORS NAME, NUMBER AND FAX _____

SECONDARY INSURANCE

TYPE_____INSURED'S NAME _____

INSURED'S DATE OF BIRTH _____

POLICY# _____GROUP_____

I agree to pay for Medical Services rendered at Andrews Institute Physical Medicine. I understand that there are payment plans available at my request. I am responsible for any balance that my Insurance Company does not pay.

X _____DATE _____

Release of Information: I authorize Andrews Institute Physical Medicine to release medical information requested by health insurance, Medicare, or Third Party payers in order to assist in the payment of claims.

X _____DATE _____

I authorize the following to pick up medical records, prescriptions, letters, or other documents pertaining to me and my care.

NAME_____RELATIONSHIP_____

Please note, unless otherwise indicated, copies of your medical records will be sent to your Primary Care Physician and Referring Doctor.

Please Print

Today's Date: _____ TEMP: _____BP:_____
(This form is good for 1 year from above date). HT: _____ P: _____
WT: _____ R: _____
BMI: _____

NEW PATIENT HISTORY AND PHYSICAL FORM
(For new patients and to be updated annually)

PATIENT'S NAME: **AGE:**

CHIEF COMPLAINT: (Why you are here today)

HISTORY OF PRESENT ILLNESS:

Location of pain / problem?
How long have you had this problem?
How did the problem **start**?
How often do you have the pain?
What makes it **worse**?
What makes it **better**?
What **associated problems** have you been having?
What is the **severity** of your pain? Mark an **X** on the appropriate circle below

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

What does the pain feel like? (Throbbing, shooting, sharp, etc.)

GENERAL MEDICAL INFORMATION:

My general health is: (Please check one) ☐ Excellent ☐ Very good ☐ Good ☐ Fair

Who is your family doctor: _____ **Date of last visit:** _____
Are you pregnant or attempting to get pregnant ☐ **Yes** ☐ **No**

List any medications you are currently taking including strength and how taken:

Name:	**Dosage:**	**How Often:**	**Name:**	**Dosage:**	**How Often:**

Are you currently taking (or have you taken in the past) diet pills or herbal supplements? ☐ **Yes** ☐ **No**
If yes, write the name of the pills/ supplement and date last taken: _____

ALLERGIES:
List medications and / or foods that you are ALLERGIC to or have had a bad reaction to:
_____

What kind of reaction did you have?

_____

Please Print

PAST MEDICAL HISTORY:

Check any problem you have ever been treated for and indicate the year of treatment:

- ☐ Arthritis
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Brittle Bones
- ☐ Broken Bones
- ☐ Ruptured Disc
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Diabetes
- ☐ Stomach Ulcers
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ Blood Clots
- ☐ Varicose Veins
- ☐ Kidney Disease
- ☐ Bladder Infection
- ☐ Sickle Cell Anemia
- ☐ Hepatitis A/B/C
- ☐ Cirrhosis
- ☐ Gall Stones
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Polio
- ☐ Venereal Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ GERD
- ☐ Cancer: Type_____
- ☐ Hereditary Defects
- ☐ Glaucoma
- ☐ Depression
- ☐ Drug Dependency / Alcoholism
- ☐ Head Injury
- ☐ Convulsions / Seizures
- ☐ Fainting Spells
- ☐ Insomnia
- ☐ Gout
- ☐ Thyroid Problems
- ☐ High Cholesterol/Triglycerides

SURGICAL / HOSPITALIZATION HISTORY:

PRIOR SURGERIES:

Type of Surgery	Date of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

PRIOR NON-SURGICAL HOSPITALIZATIONS, MAJOR ILLNESSES OR INJURIES:

REASON FOR ADMIT	Date of Admit
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Occupation:_____Marital Status: S ☐ M☐ W☐ DV☐ SP☐
Are you working now?_____If no, when did you last work?_____
Place of birth:_____Grade of school completed:_____

I live in a: ☐ House ☐ Apartment ☐ Condominium ☐ Mobile Home ☐ Boat
My home is a: ☐ Single level ☐ Multi-level # of stairs to enter:_____ Inside stairs:_____
I live: ☐ Alone ☐ with spouse ☐ with parents ☐ with children Other_____

Current Alcohol Consumption:
Type: ☐Beer ☐Wine ☐Whiskey ☐None
Frequency: ☐Daily ☐Weekly ☐Monthly ☐Never
If you have quit, how long? _____

Current Tobacco Use:
Type: ☐Cigarettes ☐Pipe ☐Chew ☐None
How much used daily? _____
and for how long?_____
If you have quit, how long? _____

Please Print

FAMILY HISTORY:

Mother: **Living:** ☐ **YES or** ☐ **NO Age:** _____ **Condition of health:** _____
If deceased, cause of death and age at death: _____

Father: **Living:** ☐ **YES or** ☐ **NO Age:** _____ **Condition of health:** _____
If deceased, cause of death and age at death: _____

Have you or any member of your family ever had? (Indicate relative by placing a letter next to problem):
F-(father), M-(mother), GF-(grandfather), GM-(grandmother), B-(brother), S-(sister), C-(Child), U-(uncle), A-(aunt)

_____CANCER	_____HIGH BLOOD PRESSURE	_____HEART DISEASE
_____HEART ATTACK	_____DIABETES	_____STROKE
_____ARTHRITIS	_____SEIZURES	_____TUBERCULOSIS (TB)
_____KIDNEY PROBLEMS	_____HEPATITIS	_____ASTHMA
_____EMPHYSEMA	_____COPD	_____LUPUS
_____HIV/AIDS	_____OSTEOPOROSIS	_____REACTION TO ANESTH
_____LUNG PROBLEMS	_____BACK INJURY	_____STOMACH PROBLEMS
_____ULCERS	_____DEPRESSION	_____SKIN BREAKDOWN

SYMPTOM / SYSTEMS REVIEW:

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GENERAL HEALTH

CONSTITUTIONAL SYMPTOMS

- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Unexplained bleeding
- ☐ Fever/Chills
- ☐ Night sweats
- ☐ Recent weight change
- ☐ Other_____
- ☐ **NO PROBLEMS**

HEAD/FACE

- ☐ Headaches
- ☐ Lesions or scars
- ☐ Reduced facial strength
- ☐ Recent hair loss
- ☐ Masses
- ☐ Facial paralysis
- ☐ Scalp tenderness
- ☐ Other_____
- ☐ **NO PROBLEMS**

EYES

- ☐ Blurred or double vision
- ☐ Dryness
- ☐ Redness of the eyes
- ☐ Visual disturbances
- ☐ Wear glasses or contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other_____
- ☐ **NO PROBLEMS**

EARS / NOSE / MOUTH / THROAT

- ☐ Earaches or drainage
- ☐ Bad breath or bad taste
- ☐ Bleeding gums
- ☐ Hearing loss
- ☐ Mouth sores/ulcers
- ☐ Frequent sore throat
- ☐ Ringing in the ears
- ☐ Difficulty swallowing
- ☐ Voice changes
- ☐ Sinus infections/problems
- ☐ Dryness of the mouth
- ☐ Sinus tenderness
- ☐ Nosebleeds
- ☐ Hay fever
- ☐ Dentures
- ☐ Other_____
- ☐ **NO PROBLEMS**

NECK

- ☐ Masses
- ☐ Tenderness
- ☐ Thyroid tenderness
- ☐ Vein distension
- ☐ Swollen glands in the neck
- ☐ Pain
- ☐ Other_____
- ☐ **NO PROBLEMS**

CHEST / BREAST

- ☐ Breast discharge
- ☐ Breast implants
- ☐ Breast lump
- ☐ Breast pain
- ☐ Other_____
- ☐ **NO PROBLEMS**

CARDIOVASCULAR

- ☐ Chest pain or pressure
- ☐ Blood clots
- ☐ Swelling of feet or ankles
- ☐ Fast or irregular heart beat
- ☐ Palpitations
- ☐ Swelling of the hands
- ☐ Heart trouble
- ☐ Leg cramps
- ☐ Poor circulation
- ☐ Other_____
- ☐ **NO PROBLEMS**

RESPIRATORY

- ☐ Wheezing
- ☐ Chronic or frequent coughs
- ☐ Cough / mucous production
- ☐ Difficulty breathing
- ☐ Dry cough
- ☐ Shortness of breath/lying flat
- ☐ Shortness of breath/walking
- ☐ Pain on breathing
- ☐ Spitting/coughing blood
- ☐ Other_____
- ☐ **NO PROBLEMS**

SYMPTOM / SYSTEMS REVIEW: (continued)

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GASTROINTESTINAL

- ☐ Heartburn or indigestion
- ☐ Changes in bowel movements
- ☐ Rectal bleeding or blood in stool
- ☐ Painful bowel movements
- ☐ Constipation
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Abdominal pain
- ☐ Frequent diarrhea
- ☐ Other_____
- ☐ **NO PROBLEMS**

GENITOURINARY

- ☐ Burning or painful urination
- ☐ Blood or pus in urine
- ☐ Vaginal discharge
- ☐ Incontinence or dribbling
- ☐ Pain with periods
- ☐ Sexual difficulty
- ☐ Genital rash or ulcers
- ☐ Irregular periods
- ☐ Testicular pain
- ☐ Change in force or strain urinating
- ☐ Prostate problems
- ☐ Other_____
- ☐ **NO PROBLEMS**

LYMPHATIC/HEMATOLIGIC

- ☐ Bleeding or bruising tendency
- ☐ Enlarged glands
- ☐ Phlebitis
- ☐ Slow to heal after cuts
- ☐ Other_____
- ☐ **NO PROBLEMS**

MUSCULOSKELETAL/EXTREMITIES

- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty climbing stairs
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Numbness or tingling
- ☐ Paralysis
- ☐ Walk with a limp
- ☐ Walk with assistive device
- ☐ Walk only limited distances
- ☐ Weakness of muscles or joints
- ☐ Other_____
- ☐ **NO PROBLEMS OTHER THAN REASON FOR VISIT**

NEUROLOGICAL/PSYCHIATRIC

- ☐ Convulsions or seizures
- ☐ Frequent/recurring headaches
- ☐ Numbness or tingling sensation
- ☐ Tremors
- ☐ Memory loss or confusion
- ☐ Light headed
- ☐ Loss of consciousness
- ☐ Feeling blue
- ☐ Dizziness
- ☐ Other_____
- ☐ **NO PROBLEMS**

INTEGUMENTARY / SKIN

- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Psoriasis
- ☐ Rash or itching
- ☐ Skin nodules or bumps
- ☐ Other_____
- ☐ **NO PROBLEMS**

PLEASE LIST OTHER PERTINENT INFORMATION YOUR PHYSICIAN SHOULD KNOW:

_____

_____

_____

I hereby attest that I personally completed this form and all the information is true and correct:

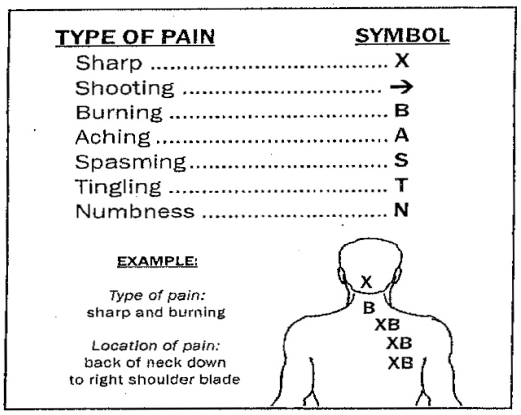
_____ _____

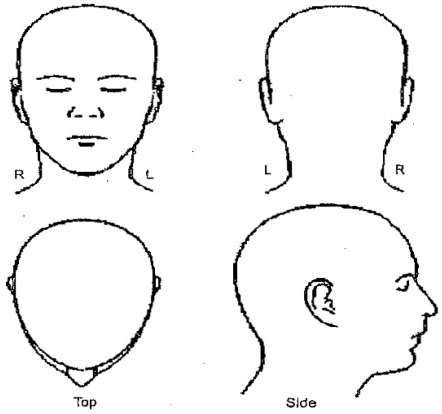
Signature of Patient or Guardian completed form: **Date:**

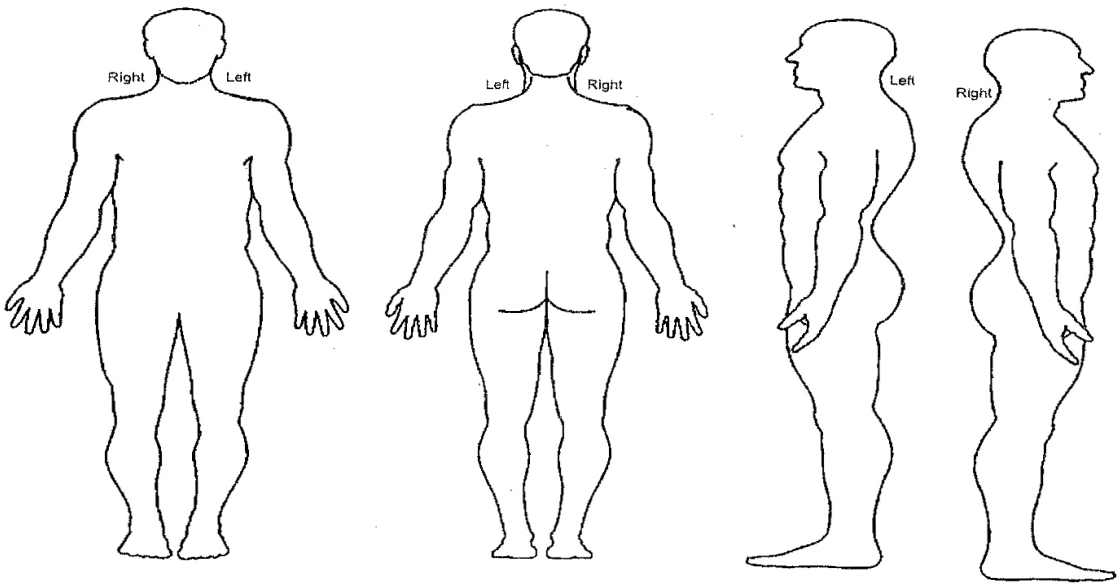
HISTORY FORM REVIEWED BY:_____Date:_____

Physician's or Physician Assistant's Signature

Please use the following symbols to indicate the type and location of your pain on the drawings below.







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

Patient's Signature_____