

Baylis & Brown Orthopedics

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: African American Asian Caucasian Native American/Alaskan Pacific Islander Other _____
 Unknown Decline to Answer

Ethnicity: Hispanic Non-Hispanic Unknown Decline to Answer

Preferred Language: English Spanish Chinese Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: Right Left Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

Pain Numbness/Tingling Fracture Stiffness Annual Follow Up Other: _____

Shoulder	<input type="radio"/> Right	<input type="radio"/> Left	Pelvis	<input type="radio"/> Right	<input type="radio"/> Left	Neck	<input type="radio"/>
Upper Arm	<input type="radio"/> Right	<input type="radio"/> Left	Hip	<input type="radio"/> Right	<input type="radio"/> Left	Upper Back	<input type="radio"/>
Elbow	<input type="radio"/> Right	<input type="radio"/> Left	Thigh	<input type="radio"/> Right	<input type="radio"/> Left	Mid Back	<input type="radio"/>
Forearm	<input type="radio"/> Right	<input type="radio"/> Left	Knee	<input type="radio"/> Right	<input type="radio"/> Left	Low Back	<input type="radio"/>
Wrist	<input type="radio"/> Right	<input type="radio"/> Left	Lower Leg	<input type="radio"/> Right	<input type="radio"/> Left	Buttocks	<input type="radio"/>
Hand	<input type="radio"/> Right	<input type="radio"/> Left	Ankle	<input type="radio"/> Right	<input type="radio"/> Left	Tail Bone	<input type="radio"/>
Thumb	<input type="radio"/> Right	<input type="radio"/> Left	Foot	<input type="radio"/> Right	<input type="radio"/> Left		
Index	<input type="radio"/> Right	<input type="radio"/> Left	Great Toe	<input type="radio"/> Right	<input type="radio"/> Left		
Middle	<input type="radio"/> Right	<input type="radio"/> Left	2nd Digit	<input type="radio"/> Right	<input type="radio"/> Left		
Third	<input type="radio"/> Right	<input type="radio"/> Left	3rd Digit	<input type="radio"/> Right	<input type="radio"/> Left		
Little	<input type="radio"/> Right	<input type="radio"/> Left	4th Digit	<input type="radio"/> Right	<input type="radio"/> Left		
			5th Digit	<input type="radio"/> Right	<input type="radio"/> Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

- No Injury Injury Injury at Work Auto Accident
 Sport Injury Prior Surgery Surgery Complication

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: Acute (sudden) Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? Yes No

Attorney Name: _____

Will there be any legal actions with respect to this problem? Yes No

3. Have you had a problem like this before? Yes No

Describe: _____

4. Have you been seen in an ER for this problem? Yes No

Treating ER: (ex. Memorial West) _____ **Date:** (mm/dd/yyyy) _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

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

6. Do the symptoms wake you from sleep?

- Yes No

7. Please describe the symptoms:

- Sharp Dull Stabbing Throbbing Aching Burning Shooting

8. What is the timing of the symptoms?

- Constant Intermittent (comes and goes)

9. Is the problem getting better or worse?

- Getting better Getting worse Unchanged

10. What makes the symptoms worse?

- Squatting Kneeling Sitting Bending Stairs Twisting Moving Lying in bed
 Running Walking Athletics Standing Gripping Lifting Reaching Overhead

11. Are there any other symptoms associated with this problem?

- Redness Bruising Swelling Numbness Stiffness Limping Clicking Locking
 Popping Tingling Weakness Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

- None X-rays MRI CT Scan Nerve Test (EMG/NCV) Bone Scan

Have you had any prior treatment for this problem? Yes No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
Heat	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
Rest	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
NSAIDs	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Muscle Relaxers	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Chiropractor	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Physical Therapy	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Home Exercise Program	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Surgery	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Injections	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Bracing	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
TENS unit	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____

Other/Comments: _____

Select all previous hospitalizations/surgeries: **None**

<input type="radio"/> Aneurysm (Brain) Surgery	<input type="radio"/> Hysterectomy	Orthopedic on side:	Right	Left
<input type="radio"/> Aortic Bypass / Vascular Surgery	<input type="radio"/> LAP Band / Gastric Bypass Surgery	Arthroscopy: Knee	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Appendectomy	<input type="radio"/> Lumpectomy	Arthroscopy: Shoulder	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Cataract (Eye) Surgery	<input type="radio"/> Mastectomy	Carpal Tunnel Release	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Cholecystectomy (Gallbladder)	<input type="radio"/> Malignancy/Cancer	Rotator Cuff Repair	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Heart Surgery	<input type="radio"/> Stents	Total Hip Replacement	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Hernia Repair		Total Knee Replacement	<input type="radio"/>	<input type="radio"/>
		Total Shoulder Replacement	<input type="radio"/>	<input type="radio"/>
		Spinal Surgery - Indicate Level: _____		

Other Surgery _____

Other Orthopedic Surgery _____

Medical Questions
Mark all that currently apply:
 Metal in body Claustrophobic Pregnant Sleep Apnea Uses a CPAP Snores

Are you taking blood thinners? Yes No

Review of Systems
Please indicate if you have experienced any of the following symptoms in the last 6 months?
 None for all

				None	Comments
1) CON	<input type="radio"/> Weight Loss	<input type="radio"/> Loss of Appetite	<input type="radio"/> Fatigue	<input type="radio"/>	_____
2) EYE	<input type="radio"/> Blurred Vision	<input type="radio"/> Double Vision	<input type="radio"/> Vision Loss	<input type="radio"/>	_____
3) ENT	<input type="radio"/> Hearing Loss	<input type="radio"/> Hoarseness	<input type="radio"/> Trouble Swallowing	<input type="radio"/>	_____
4) CV	<input type="radio"/> Chest Pain	<input type="radio"/> Palpitations		<input type="radio"/>	_____
5) RS	<input type="radio"/> Chronic Cough	<input type="radio"/> Pneumonia	<input type="radio"/> Shortness of Breath	<input type="radio"/>	_____
6) GI	<input type="radio"/> Heartburn, Ulcers	<input type="radio"/> Nausea, Vomiting	<input type="radio"/> Blood in Stool	<input type="radio"/>	_____
7) GU	<input type="radio"/> Painful Urination	<input type="radio"/> Blood in Urine	<input type="radio"/> Kidney Problems	<input type="radio"/>	_____
8) SK	<input type="radio"/> Frequent Rashes	<input type="radio"/> Skin Ulcers	<input type="radio"/> Lumps <input type="radio"/> Psoriasis	<input type="radio"/>	_____
9) NEU	<input type="radio"/> Frequent Falls	<input type="radio"/> Loss of Coordination	<input type="radio"/> Numbness	<input type="radio"/>	_____
	<input type="radio"/> Change in Bowel	<input type="radio"/> Change in Bladder	<input type="radio"/> Dizziness		
10) PSY	<input type="radio"/> Depression/Anxiety	<input type="radio"/> Drug/Alcohol Addiction	<input type="radio"/> Sleep Disorder	<input type="radio"/>	_____
11) ENDO	<input type="radio"/> Fever	<input type="radio"/> Heat or Cold Intolerance	<input type="radio"/> Night Sweats		
12) HEM	<input type="radio"/> Easy Bleeding	<input type="radio"/> Easy Bruising	<input type="radio"/> Anemia	<input type="radio"/>	_____

Family HistoryHave any direct relatives had any of the following disorders? None for all

Father	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			
Mother	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			
Sibling	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			

Social History

Do you smoke tobacco? Current, every day smoker Current, some day smoker Former smoker Never
 Heavy tobacco smoker Light tobacco smoker

Do you drink alcohol? Daily Occasionally Rarely Never

Marital Status: Married Single Divorced Widowed Domestic Partnership

Are you currently working? Yes No Retired Disabled If no, what date did you last work? _____

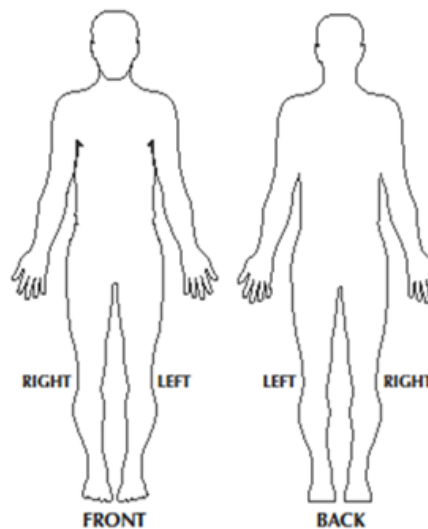
Please list work restrictions, if any: _____

Occupation: _____ **Employer:** _____ Student

Pain Diagram

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



Do you have any allergies? Yes No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"

Reaction

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Latex allergy? Yes No

Please list all medications you take on a regular basis: None

Medication

Dosage and Frequency (e.g. 20 mg, once/day)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a personal history of any of the following? None

<input type="radio"/> Aneurysm Where: _____	<input type="radio"/> Emphysema	<input type="radio"/> Kidney Disease
<input type="radio"/> Angina (Chest Pain)	<input type="radio"/> Epilepsy	<input type="radio"/> Kidney Stones
<input type="radio"/> Arthritis Type: _____	<input type="radio"/> Heart Attack	<input type="radio"/> MRSA Infection
<input type="radio"/> Asthma	<input type="radio"/> Hepatitis Type: _____	<input type="radio"/> Pacemaker
<input type="radio"/> Bone or Joint Infections	<input type="radio"/> HIV / AIDS	<input type="radio"/> Phlebitis (Blood Clots)
<input type="radio"/> Cancer Type: _____	<input type="radio"/> High Cholesterol	<input type="radio"/> Pulmonary Embolism
<input type="radio"/> Chemotherapy / Radiation	<input type="radio"/> Hypertension	<input type="radio"/> Reaction to Anesthesia Type: _____
<input type="radio"/> COPD	<input type="radio"/> Hyperthyroidism	<input type="radio"/> Seizures
<input type="radio"/> Congestive Heart Failure	<input type="radio"/> Hypothyroidism	<input type="radio"/> Stomach Ulcers
<input type="radio"/> Diabetes Type: _____ Last A1C: _____	<input type="radio"/> Stroke / TIA	<input type="radio"/> Tuberculosis

Please list any other conditions or details of conditions marked above:

Signature

Date

Baylis & Brown Orthopedics
350 N Pine Island Rd. Suite 200
Plantation, FL 33324

Authorization for Release of Medical Records/Payment Authorization/Practice Policies

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Not to be released to anyone

Physician Name/Office: _____

Check information requested and how to be sent. X-rays incur a cost of \$10.00

_____ Entire Record _____ X-Ray _____ Email _____ Fax _____ US Mail

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number

If unable to reach me: you may leave a detailed message please leave a message asking me to return your call

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released by this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the authorization. This authorization is valid for one year from date of signature if not specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for subsequent unauthorized disclosure and the information may not be protected by federal confidentiality rules. I also understand that although the practice makes its best efforts, the transmission of information via email or text between the practice and myself may not be encrypted and secure. If I have any questions about disclosure of my health information, I can contact the Medical Records Department at (954) 476-8800.

Assignment of Insurance Benefits: I hereby authorize payment directly to Baylis & Brown Orthopedics ("BABO") and assign to them any and all rights and benefits that I or the patient may have under and policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly. I understand that I am financially responsible to practice for charges not covered by this assignment.

Consent to Medical and Surgical Treatment: The undersigned hereby consents to all medical care and services, surgical treatments. Examinations, tests and procedures, including but not limited to x-ray examination, laboratory and diagnostics

procedures and tests, anesthesia, which a physician, their employees, nurses, associates, assistants, or designees may deem advisable to the undersigned patient during this treatment.

Payment Guarantee: The undersigned patient and guarantor, if any, hereby agree to BABO charges to BABO in accordance with the regular rates and terms of BABO and agree to pay for any charges not covered by any third party payer. The medical practice files insurance as a courtesy to the patient, but the patient is ultimately responsible for the payment of the total incurred charges. The undersigned agrees that if the account is turned over to a collection agency or attorney, that the undersigned patient shall be obligated to pay the outstanding balance plus all court, collection, and attorney costs. The undersigned agrees that any overpayment collected on this account may be applied to any delinquent account for which the undersigned patient is legally responsible.

Referral Policy: The purpose of this notice is to inform you of our office policy regarding referrals. If your plan requires that you obtain a referral for specialist services, it is your responsibility to do so. We do not contact the primary care physician (PCP) for referrals. If you present to the office without a referral you have the option of paying out of pocket or rescheduling your appointment until you have obtained a referral.

For your convenience, we will accept faxed referrals. However, it is the patient/parent/guardian's responsibility to ensure that the referral is received in the office prior to the appointment. Please feel free to call our office to verify that they referral has been received before arriving to our office if the referral is being faxed. We will not be responsible for referrals that are expired or otherwise invalid. Please request a copy of your referral if one has not been provided to you to enable you to track when a referral is needed. Please advise our office immediately of any changes in your insurance policy as this may void any referrals on file and may result in unnecessary out of pocket expenses to you. If you need assistance in understanding your insurance policy, please see one of our administrative staff members or management and we will gladly assist you.

Controlled Substances Policy: I am responsible for my controlled substance and all prescription medications. If the prescription or medication is lost, misplaced or stolen or I use it sooner than prescribed, I understand that it will not be replaced. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medications from BABO The exception would be if I were hospitalized and under the care of another physician. I understand that if I violate any of the above conditions, my relationship with BABO may be terminated. I understand that, I may be reported to the Drug Enforcement Authorities, other physicians and local medical facilities.

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____