

HEALTH HISTORY: Adult Patient Questionnaire

PATIENT NAME: _____ BIRTH DATE: ____/____/____

This history form provides us with information to help us meet all your healthcare needs. Please complete this form, answering each question. This is a confidential part of your medical record and will be kept in this office.

Today's Date: _____

When was your last physical exam? _____

Place of Birth: _____

Name of doctor: _____ Phone: _____

Highest level in school: _____

Please list all serious illnesses, operations, and other

Occupation: _____

hospitalizations you have experienced and indicate year

Previous occupations: _____

occurred: _____

Marital Status: _____

Hobbies: _____

Exercise/recreation: _____

Habits:

Smoking (type & amount per day) _____

If former smoker, date quit: _____

Alcohol (type & amount per week): _____

Caffeine (type & amount per day): _____

Street drugs (type & amount per day): _____

Usual weight: _____ My ideal weight: _____

Date of last dental exam: _____

Please list all allergies (food, drugs, environment): _____

Please list all medicines you are currently taking (include non-prescription drugs):

Describe all serious accidents, sever injuries, head injury, fractures or broken bones (include date occurred):

Any history of family violence? _____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

PAST MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles:	no	yes	Heart Disease:	no	yes	Diabetes:	no	yes
Mumps:	no	yes	Arthritis:	no	yes	Cancer:	no	yes
Chickenpox:	no	yes	Venereal			Polio:	no	yes
Whooping			Disease:	no	yes	Glaucoma:	no	yes
Cough:	no	yes	Anemia:	no	yes	Hernia:	no	yes
Scarlet Fever:	no	yes	Bladder			Blood or Plasma		
Diphtheria:	no	yes	Infections:	no	yes	Transfusions:	no	yes
Smallpox:	no	yes	Epilepsy:	no	yes	Back trouble:	no	yes
Pneumonia:	no	yes	Migraine			High/low Blood		
Rheumatic			Headaches:	no	yes	Pressure:	no	yes
Fever:	no	yes	Tuberculosis	no	yes	Hemorrhoids	no	yes

MEDICAL HISTORY CONT...

Do you have now or have you had within the past year:

(Please mark the correct response beside each question)

	Never	Occasionally	Often		Never	Occasionally	Often
Weakness or Paralysis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tire Easily:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations or Fluttering of Heart:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Changes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Veins:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to cold or heat:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Fever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Belching:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Cramping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rash:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Nails or Hair:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomited or coughed up blood:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Black, tarry stools:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dark urine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infected eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination (day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear Glasses or Contacts? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination (night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last eye exam: _____				Increase in Thirst:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ring in Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from ears:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leakage of Urine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Starting Urine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nose Bleeds:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Backaches:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain or stiffness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Hoarseness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps or spasms:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeplessness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Tongue or Gums:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast lump or Discharge:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Coordination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Sputum:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain or Discomfort:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Women Only:			
Purple Fingers or Lips:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age period began _____			
Swelling of Hands, Feet or Ankle: <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# of Days period lasts _____			
				Days between periods _____			

Medical History cont...

Date of last Chest x-ray: _____

Asthma:	no	yes	Mitral Valve Prolapse:	no	yes	Thyroid Disease:	no	yes
Hives/Eczema:	no	yes	Stroke:	no	yes	Bleeding Tendency:	no	yes
AIDS or HIV+:	no	yes	Hepatitis:	no	yes	Any Other Disease:	no	yes
Infections Mono:	no	yes	Ulcer:	no	yes	(Please List) _____		
Bronchitis:	no	yes	Kidney Disease:	no	yes	_____		

FAMILY HISTORY:

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

Cancer:	no	yes	_____	Depression:	no	yes	_____
Tuberculosis:	no	yes	_____	Psychosis:	no	yes	_____
Diabetes:	no	yes	_____	Suicide:	no	yes	_____
Heart Disease:	no	yes	_____	Leukemia:	no	yes	_____
High Blood Pressure:	no	yes	_____	Migraine Headaches:	no	yes	_____
Stroke:	no	yes:	_____	Obesity:	no	yes	_____
Epilepsy:	no	yes:	_____	Thyroid Disease:	no	yes	_____
Allergies:	no	yes:	_____	Ulcer:	no	yes	_____
Anemia:	no	yes:	_____	High			
Bleeding Tendency:	no	yes:	_____	Cholesterol:	no	yes	_____
Asthma:	no	yes:	_____	Kidney Disease:	no	yes	_____
Chronic Lung Disease:	no	yes:	_____	Glaucoma:	no	yes	_____
Drug/Alcohol Prob.:	no	yes:	_____	Gout:	no	yes	_____

List the present age or the age of death of each of the following members of your family, also if living, add if their Health is good, fair, or poor. If deceased, list the cause of death.

Father:	_____	Son:	_____
Mother:	_____		_____
Brother(s):	_____		_____
	_____	Daughter:	_____
	_____		_____
Sister(s):	_____		_____

Spouse:	_____		

REVIEWED BY: _____ M.D. DATE: _____

Today's Date: _____

Patient Last Name: _____ First Name: _____ Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone w/area code: (____) _____

Date of Birth: ____ - ____ - ____ Age: _____ Sex: M F Patient SS#: _____

Occupation/employer: _____ Work Phone #: _____

Cell Phone #: _____

Spouse's Full Name: _____ Work Phone #: _____

Occupation/employer: _____ Cell Phone #: _____

Patient's Primary Care Doctor Name: _____ Phone #: _____

(Required)

Primary Insurance Name: _____ Policy Holder's Full Name: _____

(This will be the name of the person who the insurance is under, usually Mom or Dad)

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

(Required)

(Required)

****(Only complete if patient has a secondary insurance)****

Secondary Insurance Name: _____ Policy Holder's Full Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Medicaid Recipient #: _____ (if applicable)

If policyholder's address & phone # are different from patients (please provide): _____

PLEASE READ CAREFULLY AND SIGN BELOW:

Unless you are on a HMO, PPO or other type of managed care plan that we are providers for, it is OUR POLICY TO COLLECT PAYMENT IN FULL AT THE TIME OF THE VISIT. Sometimes exceptions are made so please discuss this with the receptionist or financial manager BEFORE SEEING THE DOCTOR. If you are on any type of Managed Care insurance: referrals to ancillary services will be made within your network, as stated by your insurance, unless you specifically request otherwise. Any services not covered by your insurance, HMO, PPO will be the responsibility of the insured. IT IS THE INSURER'S RESPONSIBILITY TO OBTAIN REFERRALS AND/OR PRE-AUTHORIZATIONS REQUIRED BY THE INSURANCE COMPANY. With the signature below, I hereby authorize treatment for the named child. I authorize the release of any information as deemed necessary, including x-rays, medical records, and insurance information to another Provider of service, Doctor's office or insurance company. I also authorize the assignment of benefits to **CENTRAL TEXAS PEDIATRIC ORTHOPEDICS AND SCOLIOSIS SURGERY, PA** and/or the physician rendering medical care. I understand that I am financially responsible for any non-covered services required for the care of the above named patient. **I understand the financial policies and agree to abide by them.**

Patient's Signature

Date

MEDICAL INFORMATON

Referring Doctor's Name: _____ Phone w/area code: _____

State specific symptoms, problems, or reasons for visit today: _____

If related to an accident or injury, please give full details. Date of Incident: _____

How & where did it happen: _____

Was a motor vehicle involved? _____ If yes, please advise if the other party liability and/or other insurance coverage applies (Please specify details): _____

Patient History

Please describe any unusual medical history: _____

List any family history of medical problems or orthopedic problems: _____

Is patient currently on any medications? _____ If yes, please list: _____

****Any medication allergies? _____ If yes, please list: _____

In the event of an emergency, who may we contact, other than the spouse, and release information to:

Name	Phone # w/area code	Relationship to patient

Notice concerning complaints: Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners/Attention: Investigations/1812 Centre Creek Drive, Suite 300/PO Box 149134/Austin, TX 78714-9134. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353.

Aviso sobre quejas: Se pueden presentar quejas acerca de médicos, así también como de otras personas autorizadas y registradas por la junta de Examinadores Médicos del Estado de Texas, incluyendo ayudantes médicos y acupunturitas, para investigación en la siguiente dirección: Texas State Board of Medical Examiners/Attention: Investigations/1812 Centre Creek Drive, Suite 300/PO Box 149134/Austin, TX 78714-9134. Se puede obtener ayuda para presentar una queja llamando al siguiente número telefónico: 1-800-201-9353.

For Doctor's Notations:

Central Texas Pediatric Orthopedics & Scoliosis Surgery

(Telephone) 512.478.8116 • (Fax) 512.478.9368

Central Office:

1301 Barbara Jordan Blvd. • Suite 300 • Austin, Texas 78723

North Office:

7200 Wyoming Springs Drive • Suite 700 • Round Rock, TX 78681

Please place check mark next to appropriate provider:

- Jay Shapiro, MD John Williams, MD Tony Kahn, MD Michelle Prince, MD
 Robert Dehne, MD Suzanne Yandow, MD Catherine Sargent, MD
 Kevin McHorse, PT Lauren Whitehouse, PT

Acknowledgement of Review of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Name: _____

Signature: _____

Date: _____

Relationship to Patient (if other than patient): _____

CTPO OFFICE POLICY
ON STANDARD INSURANCE AND MANAGED CARE INSURERS

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and where those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. Since many insurance companies have multiple claims addresses that can change periodically, you will be asked to provide a copy of your insurance card with each visit. If we are not providers for your health plan, you will be asked to pay for your services at the time of your visit.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service exactly what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently orders services that are not covered, such as lab work or orthopedic equipment, we and/or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Our common goal is for you to receive all of the benefits offered to you and care for your medical needs. This can be accomplished with your cooperation and help.

Payment of co-pays is required at the time services are provided. HMO participants are responsible for obtaining necessary referrals prior to scheduling an appointment. Unauthorized services will be the responsibility of the patient. Hospital fees and lab reports are billed to your insurance company by the reference lab and/or hospital. You may receive a separate bill from the hospital for any deductible or non-covered services. Should your insurance carrier require you to use specific ancillary facilities (physical therapy, labs, etc.), please inform your nurse. Failure to do so may result in charges that your insurance carrier may not cover.

Should your child need surgery or hospitalization, we file insurance claims with your insurance carrier for our physicians' fees. A copy of your insurance card and a current signed authorization form is required. Follow-up with your insurance carrier for reconsideration of your claim is your responsibility.

Special financial arrangements may be made in the business office for services after verification of coverage for any amounts not covered by insurance or if we are not contracted providers with your insurance company. Please provide us with your complete insurance information as soon as possible, including any secondary coverage which may be needed for coordination of benefits.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED. I WILL NOTIFY YOU IMMEDIATELY OF ANY CHANGES IN INSURANCE COVERAGE OR STATUS, OR OF ANY CHANGES OF ADDRESS OR PHONE NUMBERS.

Printed Name

Date

Signature



Pediatric Orthopedics

Bubblesheet

Is this a new problem or injury (less than 6 weeks duration)? Yes No

Is this a chronic problem? Yes No

Is this a re-injury? Yes No

Has there been treatment for the current problem? Yes No

Is your problem the result of an injury? Yes No

Where did the injury occur?

- At home
- at school
- at sports or exercise activity
- motor vehicle accident
- other

How did the injury occur?

- A fall
- Reaching
- Twisting
- Turning
- A collision
- Fighting
- other

Does the problem relate to the back or spine?

- Upper Back
- Mid Back
- Low Back
- Neck
- Scoliosis
- Kyphosis
- No

Patient Name: _____

Date of Birth: _____

Bubblesheet

Does the problem relate to an upper extremity (hand, wrist, arm, elbow, shoulder)?

- Decreased range of motion/ability
- Discoloration/redness
- Extra fingers
- Joint locking or catching
- Joint stiffness
- Joint pain
- Joint swelling/warmth
- Limb length discrepancy
- Muscle pain/weakness
- Unusual mass or growth
- Recent fever or illness
- Recent insect bite
- No

Does the problem relate to a lower extremity(foot, ankle, leg, knee, hip)?

- Decreased range of motion/ability
- Discoloration/redness
- Extra toes
- Joint locking or catching
- Joint stiffness
- Joint pain
- Joint swelling/warmth
- Limb length discrepancy
- Bowlegged
- In toeing
- Limp or altered gait
- Clubfoot/clubfeet
- Muscle pain/weakness
- Unusual mass or growth
- Recent fever or illness
- Recent insect bite
- No

Does today's visit relate to any of the following:

- Arthrogyrosis
- Cerebral Palsy
- Juvenile Rheumatoid Arthritis
- Marfan's Syndrome
- Neurofibromatosis
- Osteogenesis Imperfecta
- Spina Bifida
- Other
- No

Patient's Name: _____

Date of Birth: _____

Bubblesheet

Has there been any labwork in the last 3 days? Yes No

 If yes, mark the tests that apply?

CBC C-Reactive Protein Sedimentation Rate

Have there been any imaging studies in the last month?

No X-rays MRI Bone Scan CAT Scan

Are immunizations up to date? Yes No

Past Medical History

Patient's medical history: *Please mark all that apply.*

- Anemia/bleeding Disorders
- Cardiovascular Disorders (heart problems or murmurs)
- Developmental Delay
- Gastrointestinal Disorder
- Growth Disorders
- Immune Disorders
- Kidney Disorders
- Learning/attention Disorders
- Nausea and/or vomiting
- Neurological Disorders (headaches and/or seizures)
- Orthopedics Disorders
- Rheumatoid Arthritis
- Tumor of any kind
- If female-has started menses

List current medications:

List allergies:

Patient's Name: _____

Date of Birth: _____

Surgical History

Has the patient has any prior surgeries? Yes No

Hospitalization

Has the patient had any prior hospitalizations? Yes No

Family History

Please mark all that apply to your family medical history. Include natural parents, grandparents, aunts, uncles, sisters, and/or brothers. Include orthopedics problems for which adults may have been treated for as children.

- Anemia/bleeding Disorders
- Asthma
- Heart Disease
- High Blood Pressure
- Immune Disorders
- Clubfeet
- Juvenile Rheumatoid Arthritis
- Osteogenesis Imperfecta
- Scoliosis
- Problems with Anesthesia/Sedation

Social History

Does the patient participate in competitive sports? Yes No

Current Grade:

- K
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 12+

Patient Name: _____

Date of Birth: _____