

THE CENTER FOR BONE AND JOINT DISEASE  
MEDICAL HISTORY

MR# \_\_\_\_\_  
(office use only)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Right Handed: \_\_\_\_\_ Left Handed: \_\_\_\_\_ Weight \_\_\_\_\_ Height: \_\_\_\_\_

\*\*\*\*\*

Primary Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_

Who referred you to us: \_\_\_\_\_

\*\*\*\*\*

Describe present symptoms / complaints: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did this problem begin? \_\_\_\_\_

Is this a work related injury / problem? Yes or No (Please circle)

If so, how did this injury occur? \_\_\_\_\_

\_\_\_\_\_

Is an attorney working on your problem? Yes or No (Please circle)

Previous treatment for problem: \_\_\_\_\_

\_\_\_\_\_

Does anything make the problem worse? \_\_\_\_\_

Does anything make the problem better? \_\_\_\_\_

Did you bring X-Rays with you? Yes or No (Please circle) From Where? \_\_\_\_\_

\*\*\*\*\*

Please list any prior surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any other medical conditions:  
(i.e. Hypertension, Diabetes)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

List all Medications - give name & dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to medicine:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Smoking History: Chews  Smokes  Previously Smoked  \_\_\_\_\_ Packs per day None   
Recreational Drugs: Yes  No  What type - \_\_\_\_\_  
Alcohol History: Never  Previously  Occasional  Moderate to Heavy   
Marital Staus: Married  Single  Separated  Divorced  Widowed  # of Children \_\_\_\_\_  
Presently living alone

# THE CENTER FOR BONE & JOINT DISEASE

## MEDICAL HISTORY

MR# \_\_\_\_\_

(office use only)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**FAMILY HISTORY**

	MATERNAL	PATERNAL
Heart		
Lung		
Stomach		
Liver		
Kidney		
Anemia		
Diabetes		
Mental Illness		

	MATERNAL	PATERNAL
Cancer		
Bleeding Disorder		
Epilepsy/Convulsions		
Stroke		
Thyroid		
Blood Pressure		
Other		

EXPLAIN all Yes answers \_\_\_\_\_

**Have you recently had or do you now have:**

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
<b>DIGESTIVE SYSTEM</b>			<b>DIGESTIVE SYSTEM</b>			<b>ENDOCRINE/GLANDS</b>		
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chills, fever, sweats	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEAD</b>			Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Recent Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>			Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Belching	<input type="checkbox"/>	<input type="checkbox"/>	<b>BLOOD/LYMPH SYSTEM</b>		
Reading Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<b>MUSCLES/BONES</b>			Normal	<input type="checkbox"/>	<input type="checkbox"/>
Change in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
<b>EAR/NOSE/THROAT/MOUTH</b>			Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERGIES</b>		
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Degenerative Disease	<input type="checkbox"/>	<input type="checkbox"/>	None/Normal	<input type="checkbox"/>	<input type="checkbox"/>
Gum Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<b>NERVOUS SYSTEM</b>			Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleed	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>	<b>URINARY SYSTEM</b>		
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	MALE		
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Penile Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Toothache	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Get up every night to urinate	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Prostrate Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<b>SKIN</b>			Frequency	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>	Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>
Short Breath w/Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Non Healing lesion	<input type="checkbox"/>	<input type="checkbox"/>	Dysuria	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEART</b>			Itching	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALE</b>		
Normal	<input type="checkbox"/>	<input type="checkbox"/>	<b>EMOTIONAL STATUS</b>			Normal	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>	Regular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Heart Beating Fast	<input type="checkbox"/>	<input type="checkbox"/>	Nervous	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal - no periods	<input type="checkbox"/>	<input type="checkbox"/>
Difficult Breathing on activity	<input type="checkbox"/>	<input type="checkbox"/>	Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
			Depression	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
			Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>
			Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
			Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>			

Spiritual or Cultural Preference? \_\_\_\_\_ Living Will?  Yes  No

Healthcare Proxy?  Yes  No Name \_\_\_\_\_

Power of Attorney for Healthcare  Yes  No Name \_\_\_\_\_

If you have a Power of Attorney, please provide a copy of your POA for your chart. Do Not Resuscitate?  Yes  No

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGMENT OF OFFICE POLICIES RELATING  
TO PAYMENT OF MEDICAL EXPENSES**

Initial

  X   If you have a fracture we will be billing a fracture management code to your insurance. This entitles you to 90 days of follow-up care in which the office visit will be at no charge to you or your insurance. Casting supplies and x-rays are not included during these 90 days and are an additional charge. Please advise our office if your care will be followed up by an orthopaedist in another area.

  X   I understand and acknowledge that it is my responsibility to know and understand the nature and extent of any insurance coverage that may apply to medical bills for this claim. This may include any available health insurance, Medicare, Medicaid, automobile, liability or other insurance benefits. Specifically, I understand that it is my responsibility to know and be responsible for any DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE, ETC., and further acknowledge that it is not the responsibility or duty of the The Center for Bone and Joint Disease to determine this information.

  X   I understand and acknowledge that all co-payments and/or co-insurances are to be paid at the time that medical services are provided. I further understand that my account may be turned over to a collections agency and/or an attorney for collection. In that event, I will be responsible for reasonable attorney fees and costs that may apply and which are incurred in collection of the account.

  X   In the event that my check is returned for insufficient funds, I am aware that the following fees (in addition to the amount of the bill) will apply in accordance with Section 832.07, Fla Stat.:

- \$25.00 if the amount of the check does not exceed \$50.00
- \$30.00 if the amount exceeds \$50.00 but does not exceed \$300
- \$40.00 if the amount exceeds \$300.00 or 5% of the amount of the check, which ever is greater.

  X   I have been informed that The Center for Bone and Joint Disease will not retroactively file to any type of Medicaid for any service for this injury.

  X   I understand that a minimum fee of \$30.00 is charged for missed appointments. I agree to pay any missed appointment fees charged as a result of my failing to keep a scheduled appointment without providing at least twenty-four (24) hours previous notice that I will not be able to keep the appointment.

By signing below, I acknowledge that I understand and agree to the above terms. If I am signing on behalf of another, I represent that I have full legal authority and representative capacity to execute this document on behalf of the patient.

\_\_\_\_\_  
Patient / Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name (PLEASE PRINT)

\_\_\_\_\_  
Center for Bone and Joint Disease Representative

\_\_\_\_\_  
Date



**The Center for Bone & Joint Disease**  
**7544 Jacque Road**  
**Hudson, FL 34667**  
**727-697-2200**  
**Fax 727-863-8774**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice=s Notice of Privacy Practices.

You have a right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy officer at 727-697-2200 ext. 32.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Dated: \_\_\_\_\_

**Persons that may be given Private Health Information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**X** \_\_\_\_\_  
Patient or Patient=s Representative  
Print Patients=s Name: \_\_\_\_\_  
If signed by Representative, state name of  
Representative: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_