OS Orthopaedic Specialists of Central Arizona

Judah D Pifer, MD • Brad D Williams, MD

Patient Medical History – Lower Extremity

Last Name:______________________________ First Name: _______________________________MI: _____

Date of Birth: ______________________ Age: _____ Occupation: _____________ Retired? Yes☐ No ☐

Primary Care Doctor: ________________________________ Who Referred you to our office? _____________

What body part are you being seen for today? ____

Have you seen a doctor for this problem before? No ☐ Yes ☐ If yes, who? ______________________________

Were images taken? (X-ray or MRI) No ☐ Yes ☐ If yes, where? _______________________________

Did a specific injury or accident start your symptoms? No ☐ Yes ☐ Is Injury Work-Related? No ☐ Yes ☐

If yes, when was it how did the injury/ accident occur? ____

____

Are you currently involved in an accident or disability litigation/legal action? No ☐ Yes ☐

Has your pain recently: ☐ Worsened ☐ Not changed ☐ Improved ☐ Gone away

Describe when your pain occurs (check all that apply):

☐ Worse in the morning ☐ Worse during the middle of the day ☐ Worse at the end of the day

☐ Keeps or wakes me up at night ☐ Does not vary significantly during the day

Describe the type of symptoms you experience (check all that apply):

☐ Sharp/stabbing ☐ Throbbing ☐ Shooting ☐ Aching ☐ Cramping ☐ Stiffness

☐ Burning ☐ Tingling ☐Numbness

Pain is made worse by (check all that apply):

☐ Walking ☐ Running ☐ Standing ☐ Climbing ☐ Going up stairs ☐ Going down stairs

☐ Bending ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Driving ☐ Lying down ☐ Exercise

Pain is made better by (check all that apply):

☐ Walking ☐ Sitting ☐ Standing ☐ Bending ☐ Resting ☐ Lying down

☐ Heat ☐ Ice ☐ Exercise ☐ Nothing in particular makes the pain better

Please describe any limitations in your activity caused by your pain or other symptoms:

☐ Walk no more than______yards/miles; ☐ Sit no longer than_____min/hours at a time

☐ Stand no longer than____min/hours at a time; ☐ Climbing stairs;

Do you use a cane, crutches, or a walker? No ☐ Yes ☐ If yes, please circle which one.

Have you tried or been prescribed any of the following for this problem?

Anti-inflammatory medications? (Tylenol, NSAIDs, glucosamine, supplements, etc.)

No ☐ Yes ☐ If yes, which ___________________________________ and for how long? _____________

Narcotics or Pain Management for this specific issue?

No ☐ Yes ☐ If yes, which ___________________________________ and for how long? _____________

Where is/ was this? ____

Physical Therapy? (Please provide visit notes or documentation if available.)

No ☐ Yes ☐ If yes, for how long? _____________ where? _____________________________________

Address/ Phone number if not a local facility: ____

Who referred you to Physical Therapy? ____

Injections? (Cortisone, Gel, HA, Euflexxa, Synvisc, Gelsyn, etc.)

No ☐ Yes ☐ If yes, which ___________________________________ and for how long? _____________

Where did you have these done? ____

Are there any changes in medications, allergies, or new surgeries since your last visit? Please list:

____
____
____
____
____
____

Height: _____________________ Weight: _________________

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature:____ Date: _______________________

Printed Name:____ Date of Birth: ________________

*We, at OSCA, assure you that the above information is part of your personal and private medical record. As such, it will not be shared with anyone outside this office without your specific, written permission, except for circumstances wherein we are required to do so by law.

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Patient Name: ___________________________ Date of Birth: ______________

How often do you exercise? ☐Daily ☐1-2d/wk ☐3-4d/wk ☐>5 d/wk
What types of exercise do you usually do? ____

Do you smoke or chew tobacco? (please circle) No ☐ Yes ☐ If yes, how much and for how long?__________

Have you used tobacco in the past? No ☐ Yes ☐ If yes, when did you quit? ______________________
How many alcoholic beverages do you have in a day?______________A week? __________________________

Have you ever used or currently use illegal IV drugs? No ☐ Yes ☐ If yes, please explain: ________________
Have you had or now have any infectious diseases such as MRSA infection, Hepatitis, Tuberculosis, HIV/AIDS?

No ☐ Yes ☐ If so, please list: ____

What diseases, if any, are common in your family? (i.e. diabetes, heart attacks, cancer, etc.)
____

Please indicate any and all medical conditions for which you have been treated:

Under current active or past treatment?	Current	Past	*Under current active or past treatment?*	Current	Past
Heart disease or heart attack (*circle*)			Diabetes		
Congestive Heart Failure			Bladder infection		
Irregular Heartbeat			Liver Disease or Cirrhosis (*circle*)		
Hypertension (High Blood Pressure)			Kidney disease		
Bleeding Problems/ Anemia (*circle*)			Osteoporosis (weak bones)		
Blood clots in your legs or lungs (*circle*)			Rheumatoid Arthritis		
Pacemaker			Severe body aches/Fibromyalgia (*circle*)		
Stroke			COPD/ Emphysema/ Bronchitis (*circle*)		
Stomach/ Intestinal Ulcer (*circle)*			Sleep Apnea		
Gastritis/ Reflux Disease (*circle)*			MRSA Infection		
Leukemia/ Lymphoma (*circle*)			Tuberculosis		
Thyroid Disease			HIV/AIDS		
Prostate Difficulty			Rheumatoid Arthritis		
Medical Implants:			Other:		

Please list any medical implants: ____

Please list any operations you have had (names and dates):
____
____
____
____

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature:____ Date: _______________

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Patient Name: ____________________________ Date of Birth: _______________

ALLERGIES: Drugs/Foods	REACTIONS or SIDE EFFECTS	ALLERGIES: Drugs/Foods	REACTIONS or SIDE EFFECTS

Please list all medications you currently take including: Prescriptions, Over-the-Counter, Patches, Inhalers, Vitamins, Herbal Supplements, Eye Drops, and Injections.

DRUGNAME	DOSE	FREQUENCY	REASON

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature:____ Date: ________________

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Medical Information (HIPAA) Release Form

This form MUST be completed in its entirety.

Name: ____

DOB: _________________________________ SSN: ____________________

Mailing Address: _______________________________ City: ___________ St: _____ Zip: __________

Physical Address: ______________________________ City: ___________ St: _____ Zip: __________

How may we contact you?

Primary Phone #: _________________________ Main/ Home/ Cell May we leave a message? Yes / No

Secondary Phone #: _________________________ Main/ Home/ Cell May we leave a message? Yes / No

Email: ____

Do you have an Advanced Directive (Living Will) Yes / No

If yes, please bring a copy with you to your appointment

I acknowledge and am aware of the Notice of Privacy Practices: ☐ Yes ☐ No

Emergency Contact(s):

1. ________________________________ Relationship: _______________ Phone: _________________

2. ________________________________ Relationship: _______________ Phone: _________________

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information to the following:

☐ Spouse / Significant Other: ____

☐ Children: ____

____

☐ Other: ____

☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Signature: ____ Date: ________________

(Patient or legally authorized individual)

Printed Name: ____

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Patient Name: ____DOB: ________________

Consent for Treatment:

I authorize performance of necessary medical and/or surgical treatments. These medical services are to be performed by a licensed medical professional and/or appropriate staff of their choice in the medical facility of their choice. (i.e. office, hospital, outpatient facility, etc.}

If patient is a minor, who is authorizing treatment:

Name: ____DOB: ____________________

SSN: _________________________ Relationship: ______________________________

Driver's License: ___________________________ Phone: ______________________________

I hereby authorize the above listed providers to furnish information to Insurance Carriers/Workers Compensation concerning my illness and treatments and information needed to determine benefits or benefits for related services. I hereby authorize payment of insurance benefits directly to the above listed billing provider. I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I further agree to pay all collection fees, attorney fees and other collection costs that may be incurred to enforce collection of any amount outstanding.

I request that payment of authorized Medicare Benefits be made directly to the above listed billing provider for any services furnished to me by that provider. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize the release of medical records to and from all hospitals, medical service companies, insurance companies and other physicians assisting in the care of the patient. Authorization is also given for a copy of office notes to be mailed to the patient if requested.

Signature: ____ Date: _______________

(Patient or legally authorized individual)