Orozco Orthopaedics Annual Health History Form

Name: _____ Preferred Name: _____ DOB: _____/_____/_____

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Primary Insurance: _____ Member ID: _____ Group: _____

Insurance Subscriber Name: _____ DOB: _____ Relation: _____

Secondary Insurance: _____ Member ID: _____ Group: _____

Insurance Subscriber Name: _____ DOB: _____ Relation: _____

Primary Care Doctor: _____ Cardiologist: _____

Other Physician (ex. Pulm.) :_____Other Physician:_____

Preferred Lab and City: _____

Name of person/ physician making referral: _____

Occupation/Job Current or Previous: _____ Retired: ☐ Yes ☐ NO

Do you have any open worker's compensation cases, personal/injury/ slip and fall or auto claims ☐ Yes ☐ No
If so what body part: _____

MEDICAL/ SURGICAL HISTORY

Allergies: ☐ NO KNOWN DRUG ALLERGIES ☐ LATEX OTHER: _____

Height: _____ Weight: _____

Past Medical History		**Past Surgical History with Dates/ Year**
1. ☐ high blood pressure	6. ☐ high cholesterol	1. _____
2. ☐ diabetes	7. ☐ COPD	2. _____
3. ☐ sleep apnea	8. ☐ cancer:	3. _____
4. ☐ kidney disease	9. ☐ Other:	4. _____
5. ☐ blood clots	10. _____	5. _____

Check the box if you do not have any medical conditions ☐

Vaccination History

Influenza ____/____/____ Pneumonia ____/____/____, Tdap: ____/____/____

COVID: ____/____/____, ____/____/____, ____/____/____, Shingles:____/____/____

Family Medical History

Mother: _____ Father: _____ Siblings: _____

Medications (including over the counter vitamins, supplements, and pain relievers)

	Medication Name	Dose	Frequency		Medication Name	Dose	Frequency
1.				8.			
2.				9.			
3.				10.			
4.				11.			
5.				12.			
6.				13.			
7.				14.			

Social History

Marital Status (circle): M S D W Do you smoke: ☐ Yes ☐ No Former smoker ☐ Yes ☐ No Date quit: ___/___/___

Alcohol use: ☐ Yes ☐ No How often: _____ Beverage of choice: _____

Other drugs or substances used: _____

Other: _____

Living Arrangements

Do you live alone ☐ Yes ☐ No If you live alone do you have help/ support if needed: ☐ Yes ☐ No

Does your home have stairs ☐ Yes ☐ No How many? _____ Do you have reliable transportation: ☐ Yes ☐ No

Do you require assistive devices: ☐ Yes ☐ No If yes, ☐ Cane ☐ Walker ☐ Rollator ☐ Wheelchair ☐ Scooter

History of Falls ☐ Yes ☐ No Do you wear glasses ☐ Yes ☐ No Do you wear hearing aids ☐ Yes ☐ No

Hand Dominance: ☐ Right-handed ☐ Left-handed

Other important details: _____

I verify that the above information is correct to my knowledge.

Patient Signature_____ Date: _____

Orozco Orthopaedics Reason for Visit Form

NAME: _____ PREFERRED NAME: _____ DOB: _____/_____/_____

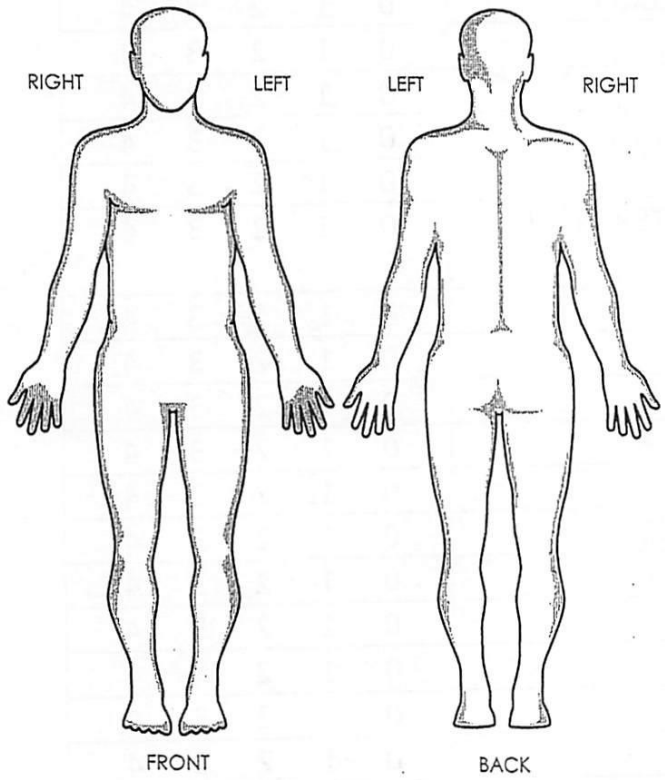
REASON FOR VISIT: _____

Is this a worker's compensation case ☐ YES ☐ NO Personal Injury/slip and fall: ☐ YES ☐ NO Auto ☐ YES ☐ NO

PAIN DRAWING

Mark these drawings using the symbols below that best describes your pain.

Pain X Numbness O Weakness = Ache ◊ Stabbing \



SEVERITY OF PAIN: (AT REST)

(NONE) 0 1 2 3 4 5 6 7 8 9 10 (INTOLERABLE)

SEVERITY OF PAIN: (WITH ACTIVITY)

(NONE) 0 1 2 3 4 5 6 7 8 9 10 (INTOLERABLE)

DATE OF ONSET/INJURY _____

DURATION OF PAIN _____

LOCATION OF PAIN
(Indicate body part where pain is present and then total pain to 100%)

BACK	_____ %	BUTTOCK	_____ %
LEFT LEG	_____ %	RIGHT LEG	_____ %
NECK	_____ %	SHOULDER	_____ %
LEFT ARM	_____ %	RIGHT ARM	_____ %

PAIN AGGRAVATED BY:

☐ STANDING ☐ SITTING ☐ WALKING
☐ SLEEPING ☐ DRIVING ☐ STAIRS
☐ BENDING FORWARD ☐ BENDING BACKWARD ☐ OTHER _____

PAIN RELIEVED BY:

☐ STANDING ☐ SITTING ☐ WALKING
☐ SLEEPING ☐ DRIVING ☐ STAIRS
☐ BENDING FORWARD ☐ BENDING BACKWARD ☐ OTHER _____

TREATMENT ATTEMPTED:

☐ NARCOTICS ☐ ACUPUNCTURE ☐ INJECTIONS
☐ CHIROPRACTIC ☐ MASSAGE ☐ SURGERY
☐ PHYSICAL THERAPY ☐ ANTI INFLAMMATORIES ☐ OTHER _____

Do you have numbness/weakness in your arms/legs?
☐ YES ☐ NO

Do you have any difficulties with bowel or bladder function?
☐ YES ☐ NO

How far can you walk before having to stop and rest?

_____

Do you use a cane or walker?
☐ YES ☐ NO

The above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE _____ DATE _____

FRONT AND BACK →

OROZCO
ORTHOPAEDICS

The Western Ontario and McMaster University Osteoarthritis Index (WOMAC)

Today's Date:_____ **Body Part:** _____

Name: _____ **Date of Birth:** _____

Instructions: Please rate the activities in each category according to the following:

Scale of difficulty: 0= None 1= Slight 2= Moderate 3= Very 4= Extremely

Circle ONE NUMBER for each activity

PAIN	WALKING	0	1	2	3	4
	STAIR CLIMBING/STEPS/CURBS	0	1	2	3	4
	PAIN AT NIGHT	0	1	2	3	4
	REST	0	1	2	3	4
	WEIGHT BEARING/ STANDING	0	1	2	3	4
STIFFNESS	MORNING STIFFNESS	0	1	2	3	4
	STIFFNESS OCCURRING LATER IN THE DAY	0	1	2	3	4
PHYSICAL FUNCTION	GOING DOWN STAIRS	0	1	2	3	4
	GOING UP STAIRS	0	1	2	3	4
	RISING FROM SITTING	0	1	2	3	4
	STANDING	0	1	2	3	4
	BENDING TO FLOOR	0	1	2	3	4
	WALKING ON FLAT SURFACE	0	1	2	3	4
	GETTING IN/ OUT OF CAR	0	1	2	3	4
	GOING SHOPPING	0	1	2	3	4
	PUTTING ON SOCKS	0	1	2	3	4
	LYING IN BED	0	1	2	3	4
	TAKING OFF SOCKS	0	1	2	3	4
	RISING FROM BED	0	1	2	3	4
	GETTING IN/ OUT OF BATH	0	1	2	3	4
	SITTING	0	1	2	3	4
	GETTING ON/OFF TOILET	0	1	2	3	4
	HEAVY DOMESTIC DUTIES	0	1	2	3	4
	LIGHT DOMESTIC DUTIES	0	1	2	3	4
	TALLY	___	___	___	___	

TOTAL SCORE: _____

FRONT AND BACK →

Signature Page

By initialing & signing below, you are acknowledging that you have received, read, and agree to Orozco Orthopaedics Policies.

Initial Each Line	
	Financial Policy (attached) I have read the Financial Policy. I understand and agree to this Financial Policy.
_____	**Notice of Privacy Practice (attached)** I hereby acknowledge the receipt of the Notice of Privacy Practices.
_____	I have read and understand the Viscosupplementation acknowledgement. (page 6)
_____	I have read and understand the Opioid Prescription Agreement (page 8)
_____	I have read and understand the Diagnostic Testing Results and DME acknowledgement Policy(pg 6)
_____	I have reviewed my patient FACESHEET. I confirm it is complete and accurate.
_____	I hereby assign my insurance benefits to be paid directly to the healthcare provider.
_____	I authorize Orozco Orthopaedics to release medical information required to process my claim.
_____	I consent to Text Messaging (SMS rates may apply)
_____	I consent to leaving a voicemail.
_____	I consent to treatment by Orozco Orthopaedics, I have the right to refuse any treatment or procedure.
	I authorize Orozco Orthopaedics to obtain/have access to my medication history.
_____	I authorize Orozco Orthopaedics to submit Personal Health Information at my request needed to process my disability forms.

Signature of Patient or Responsible Party _____

Printed Name _____

Date _____