

MEDICAL QUESTIONNAIRE

NAME: _____

DATE: _____

Do you currently, or have you ever had any of the following medical problems? (Please circle)

Cataracts	Colitis	Heart attack	Hepatitis	Diabetes	Blood clots
Glaucoma	Hernia	Heart disease	Gallbladder	Thyroid	High blood pressure
Easy bleeding	Kidney stone	Heart murmur	Pneumonia	Phlebitis	Low blood pressure
Anxiety	Gonorrhea	Scarlet fever	Tuberculosis	Seizures	Blood disease / Anemia
Depression	Herpes	Stomach ulcers	Asthma	Gout	Shingles / Zoster
Osteoporosis	Stroke	Heart surgery	Emphysema	Lyme Disease	<u>Arthritis</u> - Osteoarthritis
Cancer (type) _____					- Rheumatoid

Please explain any circled items, or list other problems not mentioned above. _____

Have you had SURGERY in the past? If yes, please explain. _____

List all MEDICINES and SUPPLEMENTS you are taking:

Do you have any ALLERGIES to medicines, seafood, or IV contrast dye? YES / NO

If YES, please list them below

Which of the following best describes your SOCIAL activities? (Please circle)

<u>Smoking:</u>	None	½ Pack / day	1 Pack / day	>1 Pack / day
<u>Alcohol:</u>	None	Occasional	Moderate	Heavy
<u>Exercise:</u>	None	Occasional	Moderate	Heavy

Do you have a FAMILY HISTORY of the following diseases? (Please circle, and state which relatives)

Heart Disease	_____	Osteoporosis	_____
High Blood Pressure	_____	Osteoarthritis	_____
Diabetes	_____	Rheumatoid Arthritis	_____
Stroke	_____	Cancer (what kind)	_____

***** **CONTINUE AND FILL OUT PAGE 2** *****

Are you currently, or have you recently experienced any of the follow SYMPTOMS? (Please circle)

Fever	Headaches	Weight gain	Blood in stool	Jaundice
Chills	Double vision	Weight loss	Blood in vomit	Rash
Night sweats	Ringing in ears	Weakness	Dark black stool	Hives
Tremor	Numbness	Sexual dysfunction	Constipation	Eczema
Nose bleeds	Tingling	Urethral discharge	Diarrhea	Psoriasis
Irregular heartbeat	Dizziness	Painful urination	Indigestion / reflux	Unusual moles
Chest pain	Fainting	Blood in urine	Abdominal pain	Anxiety
Trouble swallowing	Hoarseness	Cough	Swollen legs	Depression
Short of breath	Wheezing	Blood in sputum	Painful joints	Panic

Please **explain** any circled items, or list other symptoms not mentioned above.

SIGNATURE ON FILE: In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize Orthopaedic Specialists, P.C. to release information necessary to file a claim with my insurance company. I also authorize Orthopaedic Specialists, P.C. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered and direct my insurance carrier or its intermediaries to issue payment directly to Orthopaedic Specialists, P.C. or the individual physician indicated on the claim form.

I understand that I am financially responsible for any balance not covered by my insurance carrier.

I hereby consent to and authorize the performance of medical treatment and/or procedures by the physicians and others (nurses, x-ray technologists, and therapists) of Orthopaedic Specialists, P.C.

* **Medicare Patients** * - I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopaedic Specialists, P.C. for any services furnished to me by Orthopaedic Specialists, P.C. I authorize any 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 service. I authorize any holder of Medicare information about me to release to my Medicare Supplemental Insurance Carrier any information needed to determine there benefits payable for related services.

A copy of this signature is as valid as the original.

Signature (Patient or Legal Guardian)

Date

REVIEWED: _____
