CORE ORTHOPAEDIC MEDICAL CENTER

Patient Name: _____ _____ _____ _____
Title First Middle Last

Billing Address: _____ _____ _____ _____
Street City State Zip

Email: _____ Language Spoken: _____ Patient SSN: _____

DOB: ___/___/___ Age: _____ Primary Phone: _____ (Cell or Land) OK to leave message (Y/N)

Secondary Phone: _____ (Cell Land Work) Gender: M or F

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Asian ☐ American Indian/Native Alaskan

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline

Marital Status: ☐ Married ☐ Single ☐ Divorced Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Decline

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship to patient: _____

CORE Physician: _____ Primary Care Physician: _____

Referring Physician: _____

Insurance information: Primary Insurance Co: _____ Relationship to insured: _____

Subscriber's Name: _____ Subscriber's SSN: _____ Gender: M or F

Member ID #: _____ Group #: _____ Subscriber's DOB: ___/___/___

Secondary insurance Co: _____ Relationship to insured: _____

Subscriber's Name: _____ Subscriber's SSN: _____ Gender: M or F

Member ID #: _____ Group #: _____ Subscriber's DOB: ___/___/___

I authorize the following individual(s) to receive information pertaining to my medical history or treatment:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

FINANCIAL AGREEMENT

I authorize Core Orthopaedic Medical Center to bill my insurance for services rendered to me/my dependent. I authorize Core Orthopaedic Medical Center to release personal health information to treat me/my dependent, to receive payment for the care we provide, and for other health care operations. A detailed NOTICE OF PRIVACY PRACTICES is available upon request to help you understand our policies. The undersigned acknowledges receipt of this information. I understand that I am financially responsible for any and all charges not covered by my insurance for any reason. I agree to pay reasonable attorney's fees and collections fees, should the account be referred to an attorney or collection agency for collection. I understand that Core Orthopaedic Medical Center shall have the right at any time to refuse to provide medical care or treatment to me. I certify that I am the patient or am duly authorized by the patient or patient's general agent to execute this document and accept its terms. There is a 15 minute grace period for appointment check-in. Patients who fail to cancel their appointments 24 hours in advance are subject to a $50 charge.

Patient Signature: _____ Date: ___/___/___

Guardian Signature: _____ Name: _____ Relationship to Minor: _____

Past Medical History

Patient's Name: _____

DOB: _____ Date: _____

CORE MEDICAL CENTER

Allergies

Please list any known drug, food, or environmental allergies below

Current Medications

List any medications you are taking, including over-the-counter & supplements		
Medication	**Dose**	

Personal Medical History

Do you have or have you had any of the following medical conditions?		
Hypertension	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic Ulcers (stomach or duodenal)	Yes	No
Kidney Disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Thyroid Disease	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No

Family Medical History

Have any of your blood relatives (living or deceased) had any of these conditions?		
Hypertension	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic Ulcers (stomach or duodenal)	Yes	No
Kidney Disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Thyroid Disease	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No

List other medical conditions you have below:

OG/GYN for Women

Are you now Pregnant? YES NO
How many children have you had?
1 2 3 4 5 6+

Past Surgical procedures

List any surgical procedures you've had and your approximate age at the time	
Procedure	**Age**

Social History

Which best describes your situation?	
I live alone	
I live with family	
I live with friends	
I live in a structured setting with help	

What is your smoking history?	
I have never smoked	
I used to smoke	
I currently smoke	
How many packs a day?	

What is your alcohol intake?	
I do not drink alcohol	
I drink alcohol every day	
I drink once or more each week	
I drink once or more each month	
I drink rarely	

Review of Systems

NAME:_____

D.O.B._____/_____/_____

Constitutional		
Fever	Yes	No
Chills	Yes	No
Feeling Poorly	Yes	No
Feeling Tired	Yes	No
Recent Weight Gain	_____	Lbs
Recent Weight Loss	_____	Lbs

Eyes		
Eye Pain	Yes	No
Red Eyes	Yes	No
Eyesight Problems	Yes	No
Discharge from Eyes	Yes	No
Dry Eyes	Yes	No
Eyes Itch	Yes	No

Ears/Nose/Throat		
Earache	Yes	No
Loss of Hearing	Yes	No
Nosebleeds	Yes	No
Nasal Discharge	Yes	No
Sore Throat	Yes	No
Hoarseness	Yes	No

Cardiovascular		
Chest Pain	Yes	No
Irregular Heartbeat	Yes	No
Heart Rate is Fast	Yes	No
Heart Rate is Slow	Yes	No
Leg Pain/Cramps	Yes	No
Swelling in legs	Yes	No

Respiratory		
Shortness of Breath: □ At Rest □ With Exercise □ While Lying Down □ During Sleep	Yes	No
Wheezing	Yes	No
Cough	Yes	No
Asthma	Yes	No

Gastrointestinal		
Abdominal Pain	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Black Stool	Yes	No

Integumentary		
Skin Lesions	Yes	No
Skin Wound	Yes	No
Skin Itching	Yes	No
Change in a Mole	Yes	No
Breast Pain	Yes	No
Breast Lump	Yes	No

Genitourinary (FEMALE)		
Pain with Urination	Yes	No
Incontinence	Yes	No
Pelvic Pain	Yes	No
Painful menstruation	Yes	No
Vaginal Discharge	Yes	No
Abnormal Vaginal Bleeding	Yes	No

Genitourinary (MALE)		
Pain with Urination	Yes	No
Incontinence	Yes	No
Hesitancy	Yes	No
Frequent Urination	Yes	No
Genital Lesion	Yes	No
Testicular Pain	Yes	No

Musculoskeletal		
Joint Pain	Yes	No
Joint Swelling	Yes	No
Joint Stiffness	Yes	No
Arm/Leg Pain	Yes	No
Arm/Leg Swelling	Yes	No
Muscle Pain	Yes	No

Neurological		
Confusion	Yes	No
Convulsions	Yes	No
Dizziness	Yes	No
Fainting (syncope)	Yes	No
Limb Weakness (paresis)		
Difficulty Walking		

Psychiatric		
Suicidal	Yes	No
Sleep Disturbances	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Change in Personality	Yes	No
Emotional Problems	Yes	No

Endocrine		
Bulging Eyes	Yes	No
Hot Flashes	Yes	No
Muscle Weakness	Yes	No
Deepening of the Voice	Yes	No
Feelings of Weakness	Yes	No

Heme/Lymph		
Easy Bleeding	Yes	No
Easy Bruising	Yes	No
Swollen Glands	Yes	No
Swollen Glands in the Neck	Yes	No

Other: _____

_____

CORE ORTHOPAEDIC MEDICAL CENTER

MEDICAL HISTORY FORM – DR. LOREN

Name:_____ D.O.B._____/_____/_____ Date:_____

Occupation:_____ Primary Physician:_____ Referring Physician _____

Age:_____ ☐ Right ☐ Left Handed ☐ Female ☐ Male Height: _____ Weight:_____

What is the **primary body part** involved?

Shoulder	Elbow	Knee	Ankle	Hip	Wrist/Hand
☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

What is the **main** problem? ☐ Pain ☐ Stiffness ☐ Weakness ☐ Instability ☐ Swelling ☐ _____

How long ago did the symptoms start? _____ Days _____Weeks _____Months _____Years

Note any previous similar problems._____

Check the **ONE BOX** which describes best how the problem started and answer the related questions. Use the comment box to provide details or explanations.

☐ **NO KNOWN INJURY**
Was the onset ☐ Gradual or ☐ Sudden?
Indicate how/why it may have started.

☐ **SPORTS INJURY**
Sport:_____ Team:_____
Specify how and when the injury occurred.

☐ **OTHER INJURY**
Provide relevant details and date.

☐ **AUTO COLLISION**
☐ Driver ☐ Passenger; Seat Belt ☐ On ☐ Off
Did Air Bags Deploy? ☐ Yes ☐ No
Was car ☐ Repairable or ☐ Totaled?
Cost of Repair: $_____.
Describe details of auto accident.

☐ **WORK INJURY**
How did job duties/injury cause the problem?

COMMENTS:

Date of onset, if known:_____

Was this problem evaluated in the Emergency Room? ☐ Yes ☐ No. Which ER? _____ Date: _____

Describe the location of the pain. _____

Additional symptoms: ☐ Swelling ☐ Bruising ☐ Numbness/Tingling ☐ Weakness ☐ Locking/Catching ☐ Giving Way

Symptoms worsened by ☐ Standing ☐ Walking ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Twisting
☐ Lifting/Reaching ☐ Exercise/Sports (specify,_____) ☐ Daily Activities _____

Is the pain ☐ Constant or ☐ Intermittent (comes and goes)? Does the pain disrupt sleep? ☐ Yes ☐ No

On a scale of 0-10 (10 being the worst), how severe is the pain? (circle) **0 1 2 3 4 5 6 7 8 9 10**

Since the onset, the problem is now ☐ Better ☐ Worse ☐ Unchanged.

What medications have been taken for this problem? _____ ☐ Temporary Relief or ☐ No Relief.

Any additional treatments? ☐ Injection ☐ Brace ☐ Cast ☐ Physical Therapy ☐ Cane/Crutch ☐ _____

What tests/scan have been performed? ☐ XRay ☐ MRI ☐ CT ☐ Bone Scan ☐ Nerve Test (EMG/NCV) ☐ _____

Has any surgery been performed for a problem in the same area recently or in the past? ☐ Yes ☐ No

1. Procedure_____ Surgeon_____ City_____ Date _____
2. Procedure_____ Surgeon_____ City_____ Date _____

Is a lawsuit pending with regard to this injury? ☐ Yes ☐ No

Additional comments:_____

Signature _____