CONCORD ORTHOPAEDICS

RHEUMATOLOGY HISTORY FORM

Date of First Appointment: ____/____/____ Birthplace: _____

Name: _____ Birthdate: _____

Address: _____ Age: _____ Sex: _____

Referred here by: (√ check one)

____Self ____Family ____Friend ____Doctor ____Other Health Professional

Name of Person making referral _____

The name of the physician providing your general medical care _____

Do you have an orthopaedic surgeon? ___Yes ___No. If yes, Name _____

Describe briefly your present symptoms:

_____

_____

_____

_____

Date symptoms began (approximate) _____ Diagnosis given: _____

Previous treatment for this problem (include physical therapy, surgery and injection; medication to be listed later) _____

_____

_____

Please list the names of other practitioners you have seen for this problem: _____

_____

PAST PERSONAL HISTORY:

Do you or have you ever had: (√ check if "yes")

Cancer _____	Heart Problems _____	Asthma _____	Thyroid Problems _____
Leukemia _____	Stroke _____	Cataracts _____	Diabetes _____
Epilepsy _____	Depression/Anxiety _____	Stomach Ulcers _____	Rheumatic Fever _____
Bad Headaches _____	Jaundice _____	Colitis _____	Kidney Disease _____
Pneumonia _____	Psoriasis _____	Anemia _____	High Blood Pressure _____

Other Significant Illnesses (Please list) _____

Previous Operations

Type	*Year*	*Surgeon*	*City*
1)			
2)			
3)			
4)			
5)			
6)			

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Have you had any blood transfusions? ❑ No ❑ Yes What year? _____

CONCORD ORTHOPAEDICS

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of Brothers _____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of Children _____ Number Living _____ Number Deceased _____ List age of each _____

Serious illnesses of children _____

Do you know of any blood relative who has or had: (√ check and give relation)

Cancer _____ Heart Disease _____ Rheumatic Fever _____ Thyroid Problems _____

Leukemia _____ High Blood Pressure _____ Epilepsy _____ Diabetes _____

Stroke _____ Bleeding Tendency _____ Asthma _____ Tuberculosis _____

Colitis _____ Alcoholism _____ Psoriasis _____ Osteoporosis _____

Arthritis (type unknown) _____ Rheumatoid Arthritis _____ Lupus or "SLE" _____ Childhood Arthritis _____

Osteoarthritis _____ Gout _____ Ankylosing spondylitis _____

Other arthritis conditions: _____

SOCIAL HISTORY:

Never Married_____ Married_____ Divorced_____ Separated_____

Spouse_____ Alive/Age_____ Deceased/Age_____ Major Illnesses: _____

EDUCATIONS: (circle highest level attended)

Grade School Junior High School 7 8 College 1 2 3 4

High School 9 10 11 12 Graduate School

Occupation: _____ Number of hours worked / average per week _____

HABITS:

Do you drink coffee? _____Cups per day?_____

Smoking? ☐Current every day smoker or ☐ Current some day smoker ___packs/day ___year. ☐ Never Smoked

☐Former smoker ☐ this year ☐ > 1 year ☐ > 5 years ☐ > 10 years. Formerly smoked ___packs/day ___years.

Drink alcohol? ☐ None ❑ Daily ❑ 1-2 x/week ❑ 1-2 x/month ❑ 1-2 x/year

Do you use drugs for reasons that are not medical? If so, please list: _____

MEDICATIONS:

DRUG ALLERGIES: ____No ____Yes To what? _____

Type of reaction? _____

Are you currently under a pain management agreement? ❑ Yes ❑ No If so, with whom? _____

Present: (list any medication you are taking at this time. Include such items as aspirin, vitamins, laxative, calcium supplements, etc.)

Name of Drug	Dose (Include strength and number of pills per day)	How Long Have You Taken This Medication?	Please Check: Helped? A Lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

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HOME CONDITIONS:

Check one: House Apartment Do you have stairs to climb? No Yes If yes, how many? _____

Number of people in household _____Relationship, and age of each? _____

Who does the housework? _____ Who does most of the shopping? _____

GENERAL FUNCTION: Most of the time, I function (please circle one)…

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty: (√ check the appropriate response)

	Usually √	Sometimes √	No √
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)			
Walking?			
Climbing stairs?			
Descending stairs?			
Sitting down?			
Getting up from a chair?			
Touching your feet while seated?			
Reaching behind your back?			
Reaching behind your head?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with other family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a cane, crutches, a walker, or a wheelchair? (circle item)			

What is the hardest thing for you to do? _____

Are you receiving disability? Yes_____ No_____

Are you applying for disability? Yes_____ No_____

CONCORD ORTHOPAEDICS

SYSTEM REVIEW: (√ check any of those problems which apply to you)

GENERAL:
_____ Recent weight gain/amount
_____ Recent loss of weight/amount
_____ Fatigue
_____ Weakness
_____ Fever

NERVOUS SYSTEM:
_____ Headaches
_____ Dizziness
_____ Fainting
_____ Muscle spasm
_____ Loss of consciousness
_____ Sensitivity or pain of hands
_____ and/or feet
_____ Memory loss

EARS:
_____ Ringing in ears
_____ Loss of hearing

EYES:
_____ Pain
_____ Redness
_____ Loss of vision
_____ Double or blurred vision
_____ Dryness
_____ Feels like something in eye

NOSE:
_____ Nosebleeds
_____ Loss of smell
_____ Dryness

MOUTH:
_____ Sore tongue
_____ Bleeding gums
_____ Sores in mouth
_____ Loss of taste
_____ Dryness

NECK:
_____ Swollen glands
_____ Tender glands

THROAT:
_____ Frequent sore throats
_____ Hoarseness
_____ Difficulty swallowing

HEART & LUNGS:
_____ Pain in chest
_____ Irregular heartbeat
_____ Sudden changes in heartbeat
_____ Shortness of breath
_____ Difficulty breathing at night
_____ Swollen legs or feet
_____ High blood pressure
_____ Heart murmurs
_____ Cough
_____ Coughing of blood
_____ Wheezing
_____ Night sweats

STOMACH & INTESTINES
_____ Nausea
_____ Vomiting of blood or coffee
_____ ground material
_____ Stomach pain relieved
_____ by food or milk
_____ Yellow jaundice
_____ Increased constipation
_____ Persistent diarrhea
_____ Blood in stools
_____ Black stools
_____ Heartburn

KIDNEYS / URINE / BLADDER:
_____ Difficult urination
_____ Pain or burning on urination
_____ Blood in urine
_____ Cloudy, "smoky" urine
_____ Pus in urine
_____ Discharge from penis/vagina
_____ Frequent urination
_____ Getting up at night to pass urine
_____ Vaginal dryness
_____ Rash / ulcers
_____ Sexual difficulties
_____ Prostate trouble

SKIN:
_____ Easy bruising
_____ Redness
_____ Rash
_____ Hives
_____ Sun sensitive (sun allergy)
_____ Tightness
_____ Nodules / bumps
_____ Hair loss
_____ Color changes of hands
_____ or feet in cold

BLOOD:
_____ Anemia
_____ Bleeding tendency
_____ Blood "clots"
_____ Phlebitis

MENSTRUAL:
Age when periods began: _____ Periods regular: ____Yes ____No How many days apart:_____Date of last period: _____
Date of last Pap smear: _____ Bleeding after menopause:_____.

_____ _____
Patient/Guardian Signature **Date**

_____ _____
Provider Signature **Date**

CONCORD ORTHOPAEDICS

Patient Name (Please Print): _____

Date of Birth: _____

Electronic Communication Consent

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients of Concord Orthopaedics may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email address or text address from Concord Orthopaedics.

_____ (Patient initials) I consent to receive text messages from Concord Orthopaedics at my cell phone and any number forwarded or transferred to that number or emails to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders / feedback / health information, unless I request a change in writing.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders / information is: _____

The email address that I authorize to receive email messages for appointment reminders, feedback, and general health reminders / information is: _____

Concord Orthopaedics does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for details).

Patient Signature _____ Date _____

CONCORD ORTHOPAEDICS

Patient Name (Please Print): _____ **Date of Birth:** _____

Financial Policy

Medical Insurances:
We participate with and bill the following insurances: Aetna, Anthem, Cigna, Choice Care Network, CompNet PPO, First Health, Great-West Healthcare, Harvard Pilgrim HealthCare, Martin's Point, Medicare, MVP, NH Healthy Families, NH Medicaid, Oxford Health Plan, Private HealthCare System, Tufts, United HealthCare and Well Sense.

We will make a reasonable effort to bill other insurance companies; however there may not be any benefits or limited benefits for services provided by our physicians. Please be advised that it is your responsibility to contact your insurance company to determine your coverage prior to treatment.

Managed Care Insurances:
Our physicians may not be authorized to provide service for patients with managed care insurance without a referral from a primary care physician. Please contact your primary care physician for a referral authorization. If you do not have authorization prior to your appointment, you will be asked to sign a waiver accepting responsibility for payment should authorization be denied.

Some managed care plans allow you to obtain treatment without a referral. When you choose this option, there is usually an increased out of pocket expense to you.

Payment at Time of Service:
If you have no medical insurance, payment in full is expected at the time of service. Co-payments and co-insurances are due at the time of service. Patients with previous uncollectible balances are expected to pay before the provision of services.

In liability cases, we expect payment in full at the time of service and do not bill attorneys.

We accept cash, checks, debit cards, MasterCard, Visa, Discover and American Express.

Minors:
It is our policy that the individual who brings a child/ minor into our office and consents to treatment for services is accepting full responsibility for any balance due for services rendered.

I authorize assignment of insurance benefits to Concord Orthopaedics for the purpose of payment towards services rendered by Concord Orthopaedics.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered.

I have read this **FINANCIAL POLICY** and verify that all the insurance information that I have provided to Concord Orthopaedics is true, accurate and complete to the best of my knowledge.

Patient/Parent/Guardian Signature: _____

Patient/Parent/Guardian Name (print): _____ Date: _____

CONCORD ORTHOPAEDICS

PATIENT NAME: _____DATE OF BIRTH:_____

Patient Consent:

I authorize the providers of Concord Orthopaedics to administer any treatment, perform procedures and/or radiological services as deemed necessary in the diagnosis and treatment of the patient named above.

I authorize Concord Orthopaedics employees and providers to utilize my home or work phone numbers and answering machine(s) for the purpose of disclosing appointment and/or treatment information.

I authorize assignment of insurance benefits to Concord Orthopaedics for the purpose of payment towards services rendered by Concord Orthopaedics.

I acknowledge receipt of the "Notice of Privacy Practices" and consent to the use and disclosure of medical records (including records pertaining to drug and/or alcohol use, mental health, sexually transmitted disease, HIV/AIDS testing/treatment and/or other sensitive information).

I acknowledge that Concord Orthopaedics electronic health information records will be accessible to a limited number of Concord Hospital, Capital Orthopaedic Surgery Center and Speare Memorial Hospital staff to facilitate accurate and timely communication of information necessary for Concord Hospital, Capital Orthopaedic Surgery Center and Speare Memorial Hospital to provide services ordered by Concord Orthopaedics providers.

I acknowledge that Concord Orthopaedics will use reasonable means to protect the security and confidentiality of e-mail communication. However, because of the inherent risks of e-mail communication, Concord Orthopaedics can not guarantee the security and confidentiality of e-mail communication and will not be held liable for improper use and/or disclosure of confidential health information that is not caused by Concord Orthopaedics' intentional misconduct.

I understand that that some insurance carriers require that I obtain an insurance referral from my primary care provider for specialty care services prior to having medical services rendered. I acknowledge that if I do not have a referral for today's visit that I will assume full financial responsibility for the services rendered if my insurance company denies my claim for these services.

I agree that Concord Orthopaedics may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Signature:_____Date:_____
(Patient/parent/guardian signature (Must be 18 years or older)

Disclosure of Information:

If you would like us to be able to discuss your medical care and/or billing account information with anyone other than yourself, please list the name, relationship, and telephone number below.

Name	Relationship	Telephone #
Name	Relationship	Telephone #

Concord Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.