East Suburban Sports Medicine Center
MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DOB:** _____ **AGE:** _____ **EVAL DATE:** _____

WEIGHT: _____ **HEIGHT:** _____ **GENDER:** M F **MARITAL STATUS:** ☐ S ☐ M ☐ D ☐ W ☐ Other

REFERRING PHYSICIAN: _____ **FAMILY PHYSICIAN:** _____

MAIN PROBLEM AND WHEN PAIN/SYMPTOMS: _____

_____

OTHER TREATMENT (PT, CHIROPRACTIC, ETC): _____

DATE OF LAST PHYSICAL: _____ **ALLERGIES:** _____

TESTS (X-RAYS, MRI, BONE SCAN): _____

LIST OF MEDICATIONS: _____

SURGERIES: _____

EMERGENCY CONTACT: (name)_____

(home phone #)_____**(cell #)**_____

MEDICAL SCREENING

Have you or any immediate family member been told you have:

	Self		Family			Self		Family	
Cancer	Yes	No	Yes	No	Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Heart Disease	Yes	No	Yes	No
Angina/Chest pain	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Thyroid condition	Yes	No	Yes	No

Do you have a history of:

Allergies	Yes	No	Asthma	Yes	No
Kidney Disease	Yes	No	Rheumatic fever	Yes	No
Seizures	Yes	No	Hepatitis	Yes	No
Bronchitis	Yes	No	Ulcers	Yes	No

In the past 3 months have you had or do you experience:

A change in your health	Yes	No	Night Pain	Yes	No
Chest pain	Yes	No	Numbness in genital/anal area	Yes	No
Difficulty with bowel function	Yes	No	Pregnancy	Yes	No
Difficulty with bladder function	Yes	No	Vision Problems	Yes	No
Dizziness/Fainting	Yes	No	Hearing Problems	Yes	No
Fever/chills	Yes	No	Speech Problems	Yes	No
Headaches	Yes	No	Unexplained Shortness of Breath	Yes	No
Nausea/Vomiting	Yes	No	Unexplained Weakness	Yes	No
Night Sweats	Yes	No	Unexplained Weight Change	Yes	No
Numbness/tingling	Yes	No	Changes in appetite	Yes	No
Difficulty swallowing	Yes	No	Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No			

Are you currently:

Depressed	Yes	No
Under stress	Yes	No
Have a pacemaker	Yes	No

– OVER –

How are you sleeping at night? (check one) Fine ____ Moderate difficulty _____ Only with medication _____

Do you or have you smoked tobacco (circle one) No Yes; # packs/day ____ # of years ____ Last tobacco use ____

Are your symptoms: (check one) Getting worse _____ The same _____ Getting better _____

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE:

SIGNATURE _____ DATE: _____

Visual Pain Scale:

Please rate the severity of your pain by <u>circling</u> a number below:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

PLEASE INDICATE THE PAINFUL AREAS OF YOUR CURRENT SYMPTOMS:

Instructions:

- Circle each area of your pain or symptoms onto the chart below.
- Choose the number and letter from the lists below to describe your symptoms.
- Put the date each area of symptoms started for this episode to the best of your knowledge.

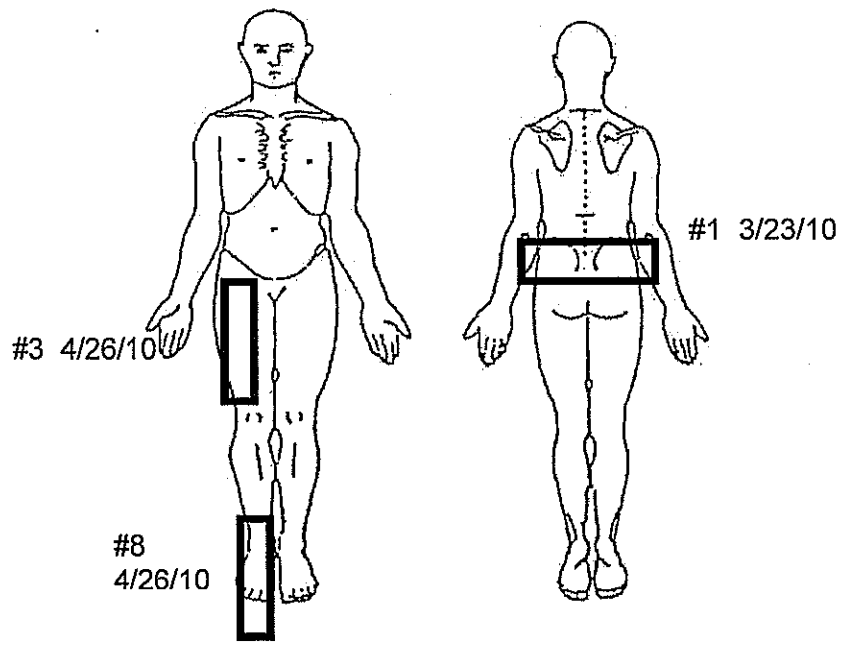
Please note the words that may help
(Use all words that apply)

1 – sharp
2 – shooting
3 – burning
4 – dull
5 – throbbing
6 – pulling
7 – ache
8 – tingling
9 – numb
10 – heavy
11 – tight
12 – stabbing

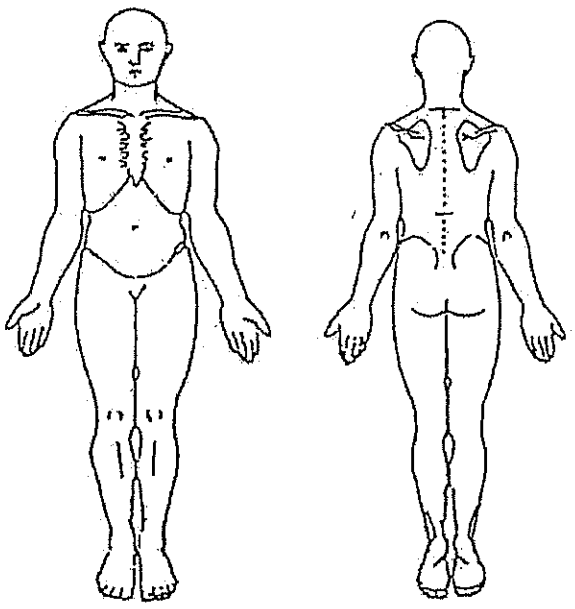
Please note the words that describe your pain may help describe the symptoms:

A. Constant (never goes away)
B. Intermittent (relieved with position change or rest)
C. Occasionally (daily or less frequent)
D. Infrequent (once a week)
E. Variable (comes and goes)

Example:



Please mark the areas of your symptoms:



Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by East Suburban Sports Medicine Center (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 4115 William Penn Highway, Murrysville, PA 15668, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____ Other (explain) _____

_____ _____
Signature of Authorized Practice Representative Date

Updated 11.29.18