

YOUNGSTOWN ORTHOPAEDIC ASSOCIATES, LTD
Bldg A - 6470 TIPPECANOE ROAD, CANFIELD, OH 44406
Bldg B - 1499 BOARDMAN-CANFIELD ROAD, BOARDMAN, OH 44512

www.youngstownortho.com

CONFIDENTIAL PATIENT MEDICAL HISTORY

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

Patient's Legal Name: _____ SS# _____ - _____ - _____

Address (Street, City, State, Zip code): _____

Phone #: _____ E-mail Address: _____

Alt Phone #: _____ Emergency contact _____ Phone _____ - _____ - _____

Preferred Pharmacy Name and Location _____

Ht: _____ Wt: _____ Sex: _____ DOB: _____ Age: _____ I am Left Handed Right Handed

Ethnicity: Caucasian African American Hispanic/ Latino Asian Other

Marital status: single married divorced widowed Preferred Language: _____

Is problem related to (check one): Job Accident/MVA Neither // Date problem occurred: _____

If this is work related did you report to your Employer? Yes No Claim # _____

WORKING STATUS

FULL DUTY LIGHT DUTY OFF DUTY PER DR. EMPLOYED UNEMPLOYED RETIRED

BRIEFLY DESCRIBE YOUR MAIN PROBLEM/COMPLAINT: _____

How long have you had this problem? _____ days months years

Medical history given by Self Other -- Relationship to patient: _____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:			
MEDICATIONS	DOSE: (MG, MCG)	TIMES PER DAY	HOW LONG?
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			

ARE YOU ALLERGIC TO ANY MEDICATIONS: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list below:	
MEDICATION:	REACTION:
MEDICATION:	REACTION:
MEDICATION:	REACTION:
MEDICATION:	REACTION:
MEDICATION:	REACTION:
LATEX ALLERGIES: <input type="checkbox"/> YES <input type="checkbox"/> NO	
FOOD / ENVIRONMENTAL ALLERGIES: <input type="checkbox"/> YES <input type="checkbox"/> NO	

YOA Physician Signature _____ Date _____

physician signature indicates all pages reviewed

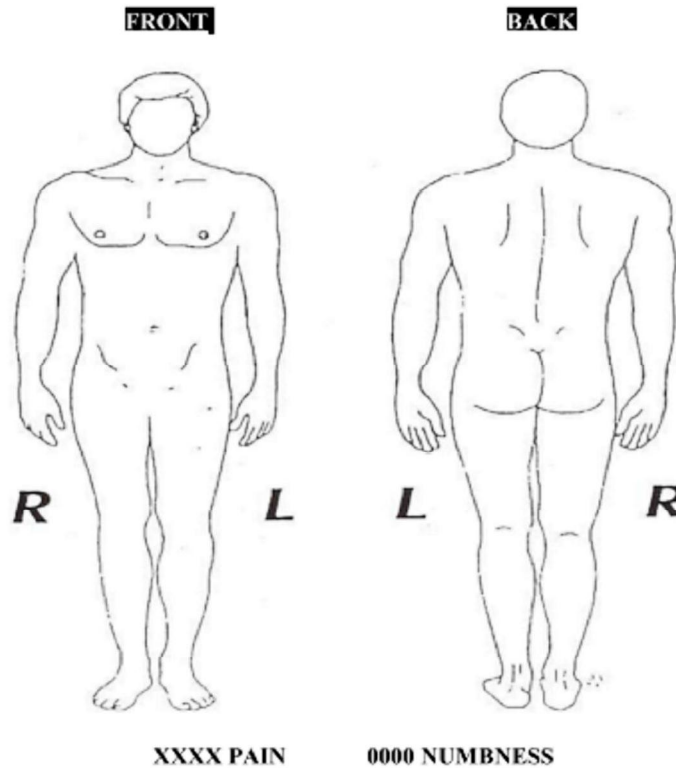
PAIN HISTORY AND ASSESSMENT:

- a. Do you have pain associated with the condition for which the doctor is seeing you? Yes No
 If yes, on a scale of 1 to 10, with 10 being the most severe, describe this pain:

10	9	8	7	6	5	4	3	2	1
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- b. Does the pain radiate ? Yes No Describe: _____
 c. When did or does it start ? _____ How long does it last ? _____
 d. Does it vary? Yes No Describe: _____
 e. What causes your pain? _____
 f. What makes your pain better? _____
 g. Is your pain aggravated by sitting standing bending lifting jumping twisting turning
 h. Do you have numbness tingling burning
 i. What do you now do for pain relief ? _____
 j. Do you hesitate to take pain medications ? Yes No Do you hesitate to report pain ? Yes No
 k. Does pain medication prescribed in the past provide pain relief? Yes No
 What works best for you? _____

USING THE SYMBOLS BELOW, PLEASE DRAW IN THE LOCATION OF YOUR SYMPTOMS ON THE DIAGRAMS.



PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10

MARK AN (X) ON THE LINE INDICATING THE USUAL DEGREE OF THE PAIN
 (0 = NO PAIN, 10 = THE WORST PAIN IN YOUR LIFE, i.e. toothache, labor pain, kidney stone(s), etc.)

PATIENT'S LEGAL NAME: _____ DATE: _____

**REVIEW OF SYSTEMS/CURRENT PROBLEM LIST
PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING**

CONSTITUTIONAL

WEIGHT GAIN LAST 6 MONTHS	WEIGHT LOSS LAST 6 MONTHS	NIGHT SWEATS	
CHILLS	FEVER		

SKIN

BLEED EASILY	ANY RASHES	BRUISE EASILY	
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EYES, EARS, NOSE, THROAT

RECENT CHANGE IN VISION	RECENT CHANGE IN SMELL	DI□□INESS	
RECENT CHANGE IN HEARING	RECENT CHANGE IN TASTE		

RESPIRATORY

SHORTNESS OF BREATH	SPUTUM	WHEE□ING	
COUGH	HISTORY OF TUBERCULOSIS		

CARDIOVASCULAR

CHEST PAIN	SHORTNESS OF BREATH WITH EXERCISE	FEET EDEMA (SWELLING)	
PALPITATIONS	HEART MURMUR	PACEMAKER	
HIGH BLOOD PRESSURE			

GASTROINTESTINAL

NAUSEA	DIARRHEA	ABDOMINAL PAIN	
VOMITING	INDIGESTION	BLOODY OR DARK STOOLS	

GENITO□URINARY

BLOOD IN URINE	UNABLE TO CONTROL BLADDER	RUSHING TO GO	
URINARY TRACT INFECTION	UNABLE TO CONTROL BOWEL	NEED TO GO FRE□UENTLY	

MUSCULOSKELETAL

CRAMPS	ATTACK OF WEAKNESS	□OINT PAIN	
	MORNING STIFFNESS	□OINT SWELLING	

CENTRAL NERVOUS SYSTEM

POOR APPETITE	NUMBNESS/TINGLING FEET	CRYING SPELLS	
PROBLEM SLEEPING	NUMBNESS/TINGLING HANDS	CONVULSIONS	

ENDOCRINE SYSTEM

DIABETIC			
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FEMALE □□PLEASE WRITE IN DATE IF APPROPRIATE

ABNORMAL VAGINAL BLEEDING	DATE:	HISTORY OF BREAST BIOPSY	DATE:
HISTORY OF NIPPLE DISCHARGE		HISTORY OF ENDOMETRIOSIS	
LAST MENSTRUAL CYCLE			

MALE □□PLEASE WRITE IN DATE IF APPROPRIATE

HISTORY OF PROSTATITIS	DATE:	DIFFICULTY URINATING	DATE:
LAST PROSTATIC EXAM		RECTAL EXAM	
RESULTS:			
PSA (PROSTATE BLOOD TEST)		RESULTS:	

PATIENT'S LEGAL NAME: _____ DATE: _____

FAMILY HISTORY

DESCRIBE CURRENT HEALTH, AGE, CAUSE OF DEATH, ILLNESS, DIABETES, CANCER, HYPERTENSION, ETC.

	AGE	ALIVE	DECEASED	MEDICAL HISTORY/CAUSE OF DEATH
FATHER				
MOTHER				
SIBLING (1)				
SIBLING (2)				
SIBLING (3)				

HABITS

TOBACCO USE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, AGE/YEAR STARTED: _____ YEAR <input type="checkbox"/> QUIT: _____					
PLEASE INDICATE <input type="checkbox"/> QUANTITY PER DAY OF THE FOLLOWING:					
CIGARETTES	<input type="checkbox"/> TY:	CIGARS	<input type="checkbox"/> TY:	CHEWING TOBACCO	<input type="checkbox"/> TY:
ALCOHOL USE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, AGE/YEAR STARTED: _____ YEAR <input type="checkbox"/> QUIT: _____					
PLEASE INDICATE <input type="checkbox"/> QUANTITY PER DAY OF THE FOLLOWING:					
BEER	<input type="checkbox"/> TY:	WINE	<input type="checkbox"/> TY:	DISTILLED SPIRITS	<input type="checkbox"/> TY:

PAST MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST? CHECK ALL THAT APPLY

	APPROX. DATE		APPROX. DATE
BOWEL DISORDERS		POLIO	
CANCER (WHERE)		PSORIASIS	
DEPRESSION		RHEUMATISM	
DIABETES		SEIZURES	
HEART DISEASE		SERIOUS INFECTION	
HIGH BLOOD PRESSURE		STROKE	
KIDNEY DISEASE		SURGERY	
LIVER DISEASE		THYROID	
MULTIPLE MYELOMA		OTHER	
PACEMAKER			

**LIST ALL THE PREVIOUS DOCTORS (MD, DO, CHIROPRACTOR)
YOU HAVE SEEN FOR YOUR MAIN COMPLAINT**

1)		4)	
2)		5)	
3)		6)	

SURGICAL HISTORY

PLEASE LIST ANY SURGERY(S) YOU HAD BY TYPE DATE AND OUTCOME:

SURGERY	DATE	PHYSICIAN

PATIENT'S LEGAL NAME: _____ DATE: _____

**INDICATE WHICH DIAGNOSTIC TESTS YOU HAVE HAD TO
EVALUATE YOUR MAIN COMPLAINT**

TEST	DATE	TEST	DATE
PLAIN XRAY		EMG/NCV/SSEP	
BONE SCAN		ARTHROGRAM	
MYELOGRAM		MRI	
CT SCAN		DEXASCAN	
DISCOGRAM		OTHER	

**LIST ALL TREATMENTS YOU HAVE HAD PRIOR TO TODAY THAT ARE
RELATIVE TO YOUR CONDITION**

TREATMENT	HELPFUL		COMMENT
<input type="checkbox"/> PHYSICAL THERAPY	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> NSAIDS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> CORTISONE INJECTIONS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> INJECTION SERIES (SYNVISC/HYALGAN)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> EPIDURALS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> FACET INJECTIONS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> MANIPULATION	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> HOME EXERCISES	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> OTHER:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> OTHER:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	

HAVE YOU EVER OR ARE YOU CURRENTLY BEING TREATED FOR ANY MENTAL HEALTH ILLNESS?

YES NO

IF YES, WITH WHOM? _____

AUTHORIZATION

By signing this authorization you are giving permission for:

- Medical and/or surgical care and treatment to be administered by the staff and physicians of Youngstown Orthopaedic Assoc. (YOA) for an adult or child.
- Payment of Medical and/or Surgical Benefits to be paid directly to the physicians of Youngtown Orthopaedic Assoc (YOA) .. That the patient is financially responsible for these charges and that the insurance carrier may only pay a portion of the charges and that the patient must pay in full any balance from deductibles, copays, coinsurance and non covered service amounts.

FULL DISCLOSURES OF OUR FINANCIAL POLICY AND THE NOTICE OF PRIVATE PRACTICES (HIPAA) FORMS ARE AVAILABLE AT OUR WEBSITE WWW.YOUNGSTOWNORTHO.COM OR COPIES ARE AVAILABLE AT THE FRONT DESK AT BOTH LOCATIONS

This authorization also serves as an authorization for Medicare Patients.

Statement to permit payment of Medicare benefits to provider, physicians and patient. Payment of authorized Medicare benefits are to be made either to the patient or on my behalf to the physicians of Youngstown Orthopaedic Assoc. (YOA) for any and all services furnished at the YOA offices.

- YOA may need to request information from other physicians, this authorization gives us permission to release or retain information relevant to your orthopaedic care from other facilities involved in your care.

This is also to acknowledge your receipt of Youngstown Orthopaedic Associates, Ltd. Notice of Privacy Practices effective April 14, 2003, as well as consent and Authorization to disclose Health Information. The notices of Privacy Practices (HIPAA) are displayed in the waiting room and on our website.

Printed Name

Signature

Date