New Patient Medical History Form

Date: _____ Patient Name:_____

Age _____ Sex: ☐M ☐F Height_____ Weight_____ Date of Birth _____

Referring Physician:		Primary Care Physician: ☐ Please check if same	
Name:	_____	Name:	_____
Specialty:	_____	Specialty:	_____
Address:	_____	Address:	_____
	_____		_____
Phone:	_____	Phone:	_____

Chief Complaint:
What is the reason for your visit: _____
Describe in detail the injury: _____
_____
Date of Injury or Pain: _____
Are you right or left handed (circle one) ? Right / Left
Were you injured? ☐ No ☐Automobile ☐ Work related ☐ Sports ☐ Home ☐ Other: _____
On a scale of 0-10 (10 is the worst) how severe is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10
Quality of the pain is: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning
The pain is: ☐ Constant ☐ Comes and goes (intermittent)
What makes your symptoms better? _____
What makes your symptoms worse? _____
What does this limit you from: _____
Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

Treatment:

Please check previous types of treatment for this problem	**Have they helped?**	
☐ Anti-inflammatory medications (i.e. Advil, Motrin, Aleve)	☐ Yes	☐ No
☐ Narcotic medications (ie Vicodin, Percocet)	☐ Yes	☐ No
☐ Brace / Splint	☐ Yes	☐ No
☐ Physical therapy	☐ Yes	☐ No
☐ Cane / Crutch	☐ Yes	☐ No
☐ Injection (Type: _____)	☐ Yes	☐ No

Have you seen an orthopedic surgeon for this problem? (If yes please list below) ☐ Yes ☐ No
Surgeon: _____

Have you had surgery for this problem? (If yes please list below) ☐ Yes ☐ No
Procedure: _____ Surgeon: _____ Date: _____
Procedure: _____ Surgeon: _____ Date: _____

Previous Tests: Please check any of the tests that you have had done for this problem
☐ X-rays ☐ MRI ☐ CT ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

Date: _____ Patient Name: _____

Past Medical History: Do you have currently or have you ever had any of the following?

Anemia:	☐ Yes	☐ No
Anesthesia Problems:	☐ Yes	☐ No
Angina:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No
Atrial Fibrillation:	☐ Yes	☐ No
Bladder Infection:	☐ Yes	☐ No
Blood Clots:	☐ Yes	☐ No
Bronchitis:	☐ Yes	☐ No
Cancer:	☐ Yes	☐ No
Cellulitis:	☐ Yes	☐ No
Congestive Heart Failure:	☐ Yes	☐ No
Coronary Artery Disease:	☐ Yes	☐ No
Depression:	☐ Yes	☐ No
Diabetes:	☐ Yes	☐ No
Dialysis:	☐ Yes	☐ No

Diverticulitis:	☐ Yes	☐ No
Elevated Cholesterol:	☐ Yes	☐ No
Emphysema/COPD:	☐ Yes	☐ No
Epilepsy:	☐ Yes	☐ No
Fractures:	☐ Yes	☐ No
Glaucoma:	☐ Yes	☐ No
Gout:	☐ Yes	☐ No
Heart Attack:	☐ Yes	☐ No
Heart Arrhythmia:	☐ Yes	☐ No
Hepatitis:	☐ Yes	☐ No
High Blood Pressure:	☐ Yes	☐ No
Hiatal Hernia:	☐ Yes	☐ No
HIV:	☐ Yes	☐ No
Kidney Disease:	☐ Yes	☐ No
Kidney Stones:	☐ Yes	☐ No

Leukemia:	☐ Yes	☐ No
Liver Disease:	☐ Yes	☐ No
Pancreatitis:	☐ Yes	☐ No
Pneumonia:	☐ Yes	☐ No
Reflux:	☐ Yes	☐ No
Rheumatoid Arthritis:	☐ Yes	☐ No
Sinus Problems:	☐ Yes	☐ No
Sleep Apnea:	☐ Yes	☐ No
Stomach Ulcers:	☐ Yes	☐ No
Stroke:	☐ Yes	☐ No
Thyroid Disorder:	☐ Yes	☐ No
TIA:	☐ Yes	☐ No
Osteoporosis:	☐ Yes	☐ No
Other: _____	☐ Yes	☐ No

Past Surgical History: [Please list all surgical procedures below]

Surgery:	Date preformed:	Surgery:	Date preformed:

Medications, Vitamins and Supplements: [Please attach list if necessary]

Name	Strength (mg)	Times/day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Date: _____ Patient Name: _____

Allergies:

Are you allergic to any metals or jewelry: ☐ Yes ☐ No If yes please list: _____
Are you allergic to Latex: ☐ Yes ☐ No
Are you allergic to any medications: ☐ Yes ☐ No If yes please list below and reaction:

_____
_____
_____
_____

Family History: Please state which relatives have any of the following:

☐ Diabetes: _____ ☐ Stroke: _____
☐ Heart Disease: _____ ☐ Cancer: _____
☐ Rheumatoid Arthritis: _____ ☐ Other: _____

Social History:

Occupation: _____
Employer: _____
Where do you live: ☐ Home ☐ Apartment ☐ Retirement Community
Who do you live with: _____
Do you use tobacco: ☐ Yes ☐ No If yes, how many per day? _____
Do you use alcohol: ☐ Yes ☐ No If yes: how many drinks per day?_____

Review of Systems: [Please check all that apply] Please explain below for any that apply:

Constitutional		
Fevers	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Musculoskeletal		
Diffuse Joint Pain	☐ Yes	☐ No
Focal Joint Pain	☐ Yes	☐ No
Muscle Pain	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Gastrointestinal		
Heartburn	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Neurological		
Poor Balance	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Respiratory		
Wheezing	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Cardiovascular		
Chest Pain	☐ Yes	☐ No
Leg Swelling	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No
Genitourinary		
Difficult Urinating	☐ Yes	☐ No

Painful Urination	☐ Yes	☐ No
Frequency	☐ Yes	☐ No
Retention	☐ Yes	☐ No
Psychiatric		
Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Eyes/Nose/Throat		
Poor Vision	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
Dif Swallowing	☐ Yes	☐ No
Integument		
Rashes	☐ Yes	☐ No
Blisters	☐ Yes	☐ No
Open Sores	☐ Yes	☐ No

_____
_____
_____

Please Sign: The information in this form is accurate, to the best of my knowledge.

Patient Signature: _____ Date: _____

For Office Use Only BMI: _____
Physician Signature: _____ Date: _____

El-Yussif Clinical Patient Knee Survey Form

Patient: _____ Date: _____
Account #: _____

Oxford Score *During the past four weeks*: (Please check **one** answer for each knee)

1. How would you describe the pain you usually have from your knee?

	None	Very Mild	Mild	Moderate	Severe
Right					
Left					

2. Have you had any trouble with washing and drying yourself (all over) because of your knee?

	No trouble at all	Very little trouble	Moderate trouble	Extreme difficulty	Impossible to do
Right					
Left					

3. Have you had any trouble getting in and out of a car or using public transport because of your knee? (whichever you would tend to use)

	No trouble at all	Very little trouble	Moderate trouble	Extreme difficulty	Impossible to do
Right					
Left					

4. For how long have you been able to walk before pain from your knee becomes severe? (with or without a stick)

	No pain / > 30 min	16 to 30 min	5 to 15 min	Around the house only	Not at all - pain severe when walking
Right					
Left					

5. After sitting at a table (i.e. for a meal), how painful has it been for you to stand up from a chair because of your knee?

	Not at all painful	Slightly painful	Moderately painful	Very painful	Unbearable
Right					
Left					

6. Have you been limping when walking, because of your knee?

	Rarely / Never	Sometimes, or just at first	Often, not just at first	Most of the time	All of the time
Right					
Left					

7. Could you kneel down and get up again afterward?

	Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
Right					
Left					

8. Have you been troubled by pain from your knee in bed at night?

	No nights	Only 1 or 2 nights	Some nights	Most nights	Every night
Right					
Left					

Please be sure to complete information for BOTH KNEES and complete BOTH SIDES of this form.

El-Yussif Clinical Patient Knee Survey Form

9. How much has pain from your knee interfered with your usual work (including housework)?

	Not at all	A little bit	Moderately	Greatly	Totally
Right					
Left					

10. Have you felt that your knee might suddenly "give way" or let you down?

	Rarely / Never	Sometimes, or just at first	Often, not just at first	Most of the time	All of the time
Right					
Left					

11. Could you do the household shopping on your own?

	Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
Right					
Left					

12. Could you walk down one flight of stairs?

	Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
Right					
Left					

ACTIVITY LEVEL Please check one box that reflects your activity level (during the past four weeks)

_____ Heavy (manual labor / physical exercise)
_____ Light (office work / walking / limited exercises)
_____ Sedentary (housework / limited walking)
_____ None (minimal mobility)

Please be sure to complete information for BOTH KNEES and complete BOTH SIDES of this form.

HENRY FORD
MACOMB HOSPITALS

Notice of Privacy Practices Acknowledgement with Opportunity to Agree or Object

I acknowledge:

A copy of the Henry Ford Macomb Notice of Privacy Practices was made available to me at the place where I went for health care services.

The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

A copy of the Notice of Privacy Practices was made available for me to keep.

If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonable after the emergency treatment situation.

I received the Notice of Privacy Practices before April 14, 2003, or no later than the first day I received health care services on or after April 14, 2003.

_____
Print Name of Patient

_____ _____
Signature of Patient or Representative Date

Optional: Opportunity to Agree or Object

It is our practice to leave messages at your home regarding appointment reminders, prescription refills, or referral/testing arrangements. (Note: Actual test results are not left as messages)

- ☐ Yes, leave messages on my answering machine or with a person who answers the phone.
- ☐ No, do not leave messages at my home. I prefer to be called at _____ or contacted by mail at this address:_____

I understand that my test results are private and will not be released to anyone other than myself unless I authorize it. I request that _____ _____
(Name) (Relationship)
be given my test results. I understand that the above instructions will be in force until I notify the organization of any changes.

_____
(Initials)

****

If an acknowledgement is not obtained, document below the good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained:

Patient's name: _____

Date of attempt to obtain Acknowledgement: _____

Reason Acknowledgement was not obtained [describe reason, such as an emergency treatment situation or substantial barrier to communication]:

_____

_____

_____ _____
Signature of Associate Date

_____ _____
Print Name Department