

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) _____

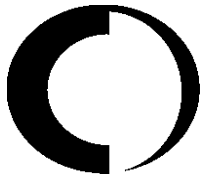
Previous Operations

| 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: _____

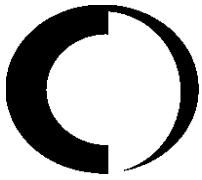
MEDICATIONS:

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. | | | | | |



CONCORD ORTHOPAEDICS

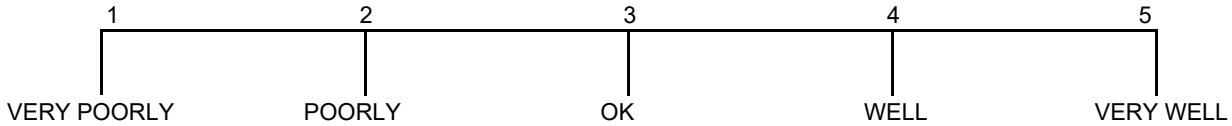
HOME CONDITIONS:

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? _____

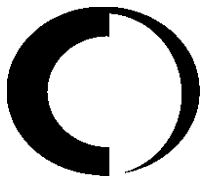
Who does the housework? _____ Who does most of the shopping? _____

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



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 _____ | | |



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

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: _____.

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

Patient/Guardian Signature

Date

Provider Signature

Date



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 _____



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: _____



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 # |
|------|--------------|-------------|
| | | |
| | | |