MEDICAL HISTORY QUESTIONNAIRE

Welcome! Who Referred You to Us Today? _____

Patient Name _____ Social Security Number _____

Gender (circle): Male Female Age _____ Date of Birth _____

Height: _____ Weight: _____ Pharmacy _____ # _____

Street _____ State _____

PAST MEDICAL HISTORY

Do you currently or have you ever had any of the following:

Diabetes	YES	NO	**High Blood Pressure**	YES	NO	**Staph Infection (MRSA)**	YES	NO
Heart Disease	YES	NO	**Seizure Disorder**	YES	NO	**High Cholesterol**	YES	NO
Sleep Apnea	YES	NO	**Stroke**	YES	NO	**Ulcer**	YES	NO
Emphysema	YES	NO	**Asthma**	YES	NO	**Heart Attack**	YES	NO
Fibromyalgia	YES	NO	**Phlebitis/Blood Clots**	YES	NO	**Bleeding Disorder**	YES	NO
Gout	YES	NO	**Thyroid Diseases**	YES	NO	**Kidney Stone**	YES	NO
Osteoarthritis	YES	NO	**GERD/Reflux**	YES	NO	**Hepatitis**	YES	NO
Rheumatoid Arthritis	YES	NO	**Depression/Anxiety**	YES	NO	**Renal Insufficiency**	YES	NO
Complications from Anesthesia	YES	NO				**Cancer**	YES	NO
						If yes, what type of cancer? _____		

List any other conditions not mentioned above _____

_____

List all surgeries or hospital procedures _____

_____

Are you allergic to any medications? **YES NO** List all allergies to medications _____

_____

Are you allergic to LATEX? **YES NO** TAPE? **YES NO** METAL? **YES NO**

List any significant injuries you have sustained _____

_____

Please list all medications you are currently taking (including any Health Supplements and Homeopathic Treatments) _____

_____

_____

_____

FAMILY HISTORY

Please indicate any significant health problems in your family history and provide which family member (i.e., mother, father, etc.)

Heart Disease _____ **Diabetes** _____ **High Blood Pressure** _____

Stroke _____ **Cancer** _____ **Other:** _____

SOCIAL HISTORY

Alcohol use (type and frequency/amount)_____

Tobacco (amount and years used)_____

Occupation_____ Employer_____

REVIEW OF SYMPTOMS (Please write N/A beside any item that does not apply)

Constitutional: Fever, sudden weight loss/gain, loss of appetite _____

Eyes: Blurred vision, double vision, difficulty seeing _____

Ear Nose Throat: Deafness, sinusitis, hoarseness, vertigo tinnitus _____

Cardiovascular: Chest pain, palpitations, irregular heartbeat, murmur_____

Cardiologist Name and City _____

Respiratory: Shortness of breath, wheezing, chronic cough, spitting blood:_____

Do you use: CPAP or BiPAP

Digestive: Abdominal pain, constipation, diarrhea, bleeding _____

Urologic: Pain when urinating, hesitancy, bleeding, incontinence _____

Gynecologic: Breast masses, pain, discharge, problems_____

Last Gynecological checkup_____ Last Pap smear_____

Skin: Rashes, lesions that do not heal, changes in moles_____

Neurological: Seizures, loss of balance/coordination, paralysis, loss of memory_____

Endocrine: Excessive thirst, excessive urination, intolerance to heat/cold _____

Blood and Lymphatic system: Anemia, bleeding tendencies, swollen nodes_____

Allergic and Immunologic: Hives, eczema, itching _____

Musculoskeletal: Stiffness, joint pain, muscle wasting _____

Other: _____

_____

Over the last two weeks, have you had thoughts that you would be better off dead or hurting yourself? **YES NO**
If you answered **no** to above question, no need to pursue further.
If you answered **yes**, please answer the following questions.
Have you wished you were dead or wished you could go to sleep and not wake up? **YES NO**
Have you had actual thoughts of killing yourself? **YES NO**

Patient Signature _____ Date: _____

Physician Signature_____ Date: _____

Updated: _____ Updated: _____ Updated: _____

Updated: _____ Updated: _____ Updated: _____

Updated: _____ Updated: _____ Updated: _____

alabama orthopaedic surgeons

PATIENT INFORMATION

Patient Name _____ Date of Birth: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Marital Status: Single Married Divorced Widowed Child Gender: Male Female

Social Security # _____ Race _____

Email _____

Employer _____ Work Phone _____

Emergency Contact _____ Phone _____ Relationship _____

PHARMACY _____ Location _____ Phone _____

PRIMARY INSURANCE

COMPANY _____

CONTRACT# _____

GROUP# _____

INSURED'S NAME _____

INSURED DOB _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE

COMPANY _____

CONTRACT# _____

GROUP# _____

INSURED'S NAME _____

INSURED DOB _____

RELATIONSHIP TO PATIENT _____

INSURANCE REFERRALS AND FINANCIAL RESPONSIBLITY

I understand that if my insurance should require a referral to see the doctor today or at any time during my treatment, it is my responsibility to provide your office with the referral. If my insurance company denies payment due to not obtaining a referral from my primary care doctor, I agree to pay Alabama Orthopaedic Surgeons in full for any charges incurred during my visit.

I hereby authorize Alabama Orthopaedic Surgeons to furnish any information concerning my medical condition, treatment, and prognosis to my insurance carriers and other treatment physicians. I hereby assign Alabama Orthopaedic Surgeons all payments for medical and/or surgical services rendered to me or my dependents due or received by third-party providers. I agree to be responsible for any amount not covered by my insurance or other providers. I hereby waiver all rights of exemption under the U.S. and Alabama Constitutions and the laws of the State of Alabama.

I agree to pay all costs of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection), and interest on the unpaid balance to be determined by our collection agency. I agree to pay up to 33% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

I hereby assign to Alabama Orthopaedic Surgeons- Insurance or other third-party benefits available for health care services provided to me. I understand that Alabama Orthopaedic Surgeons has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Alabama Orthopaedic Surgeons I agree to forward to Alabama Orthopaedic Surgeons all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt. I authorize treatment by Alabama Orthopaedic Surgeons.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ Date _____

Medical History

alabama orthopaedic surgeons

Date_____

Name:_____ Date of Birth: _____

Primary Care Physician: _____ Who Referred you?_____
Marital Status: M S D W Number of Children _____ Occupation:_____
Hand Dominance: Right Left Height:_____ Weight:_____
Are you allergic to any medication? Yes No If yes, please list: _____
_____
Are you allergic to? Latex Iodine Tape List any other allergies:_____

PLEASE FILL IN EACH OF THE FOLLOWING SECTIONS – (USE BACK OF SHEET IF NEEDED)

PRESCRIBED MEDICATIONS	Milligrams	CURRENT MEDICAL CONDITIONS (ex. Diabetes, High Blood Pressure)	SURGICAL HISTORY (Include year)
1		1.	1.
2.		2.	2.
3.		3.	3.
4.		4.	4.
5.		5.	5.

Hospital Admissions (non surgical):_____
Do you use Tobacco products? Yes No If so how much per day_____
Do you drink alcohol? Yes No If so, how much per week_____
Are you currently pregnant, or any possibilities you may be so? Yes No
Do you have any Mechanical/Magnetic/Electrical Implants? Yes No Please List:_____

GENERAL MEDICAL HISTORY – PLEASE CHECK ALL CONDITIONS THAT APPLY

Vision/Eye Problems____
Migraines____
Epilepsy____
Dizziness____
Blood Clots____
Tuberculosis____
Heart Attack____
Diabetes____
Weight Loss____
Blood in Stool____
Thyroid Disease____
Blood in Urine____
Skin Rash____
Hearing Loss____
Irregular Heartbeat____
Kidney Stones____
Cardiac Pacemaker____
Shortness of Breath____
Wheezing____
Pneumonia____
Stroke____
High Blood Pressure____
Swelling Feet/ Ankles____
Vomiting of Blood____
Cardiac Defibrillator___
Arthritis____
AIDS____
Cancer____
Depression____
Anxiety____
Gout____
Numbness____

Family History: Please circle any that apply: High Blood Pressure Heart Disease Cancer Diabetes
Anesthetic Complications Other_____

Today's Visit: Length of Symptoms_____ Have you had similar symptoms before?_____
Where is your Pain? _____
Have you seen another doctor for this problem? Yes No If yes, Who?_____
Did you have an accident or injury? Yes No If yes, date of injury:_____
Where did the accident occur? _____(ex: home, work, car accident, etc.)

Physician Signature:_____ Date_____

alabama orthopaedic surgeons

52 Medical Park Suite 220 Birmingham, AL 35235 Office: 205-838-4747 Fax: 205-838-2712

Donald Slappey Jr. M.D. * F. Spain Hodges M.D. * Jason Cobb M.D.
Timothy Cool M.D. * Jerry Ambrosia M.D

Patient Name : _____ **Date :** _____

DOB : _____

Narcotic Pain Medication Policy

Narcotic pain medications have the ability to become addictive. This policy was developed concerning narcotic pain medications because we are concerned about patient's health.

ATTENTION: Due to DEA ruling effective October 6, 2014, ALL drugs containing hydrocodone will require a **WRITTEN** prescription. NO PHONING IN OR FAXING WILL BE PERMITTED.

Your provider is under no obligation to provide any medications to you and he reserves the right to discontinue these medications at any time.

Please discuss your need for narcotic pain medications with your physician during **YOUR OFFICE VISIT**. Failure to do so will result in a delay of up to 48 hours.

1. Narcotic pain medication is not ordered for seeking second opinions.

2. If narcotic pain medication is ordered by your physician during your office visit, pre-operative or post-operative patients, the dosage will be tapered under the physician's direction. **If the patient is in need of narcotic pain medication after 3 months of being treated by the physician we will refer the patient to Pain Management or Primary Care Physician.** Patient experiencing pain may be referred to **ONE** Pain Management Clinic at the physician's discretion. **Once you are referred to a Pain Management Clinic or back to your Primary Physician, our office will no longer prescribe pain medications**.

3. If narcotic pain medications are prescribed by our physicians, you agree that our office will SOLELY manage those narcotic pain medications; in other words, you agree NOT to take narcotic pain medications prescribed by other physicians.

4. You agree to take the narcotic pain medication only as prescribed and you will not alter the dose unless changed by your physician. **Medication will not be filled early for any reason.**

5. Narcotic pain medication should be kept in a safe place. NO medications that are lost or stolen will be replaced.

6. You agree NOT to drive a motor vehicle or operate heavy machinery while taking narcotic pain medication. Also, you agree NOT to use alcohol or recreational drugs while taking any narcotic pain medications.

7. Improper use of narcotic pain medications can lead to termination of physician-patient relationship.

8. Medication will only be renewed from **8:30 a.m. – 4:00 p.m. Monday – Thursday and 8:30 a.m.- 11:00 a.m. Friday.** No pain medications will be issued during evenings, after-hours, weekends, or holidays.

9. 48 hours must be allowed for narcotic pain medications to be written as your prescribing physician is not always in the office. Please plan to pick up your prescription at our office personally or by someone listed on your HIPPA form.

Patient Signature: _____ Date: _____

RELEASE OF MEDICAL INFORMATION

Name_____ Date of Birth_____

I, hereby authorize Alabama Orthopaedic Surgeons, to furnish all information concerning my medical conditions, treatment, prognosis, test results, and appointment dates and times to the following individuals:

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

*I do not want my medical information released to anyone_____ (initial if applies)

Signature of Patient/Legal Guardian _____

Date_____

OFFICE CHARGES FOR RELEASE OF MEDICAL INFORMATION

FORMS: $25.00 fee (per form) and a 7-10 business day completion time.

X-RAYS: $10.00 fee per CD.

CHART NOTES OR OTHER RECORDS: $15.00 fee

NON-CANCELLATION OF SCHEDULED APPOINTMENTS $25.00 fee

alabama orthopaedic surgeons

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For instance, results of laboratory tests and procedures kept in your medical record will be available to all health professionals who may provide treatment to you or who may be consulted by staff members relating to your care.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information regarding dates of service, the services provided, and the medical conditions being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Alabama Orthopaedic Surgeons. Budgeting and financial reporting are examples of such usage.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For instance, we are required to report certain communicable diseases to the state's public health department.

Research. We may access your health information for research purposes; this may include Institutional Review, Board-approved and regulated clinical studies as well as retrospective reviews of patient outcomes.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you wish to change a previous authorization, you may to do so by submitting to our office a written revocation of that previous authorization. Please be aware that your decision to revoke the previous authorization will not affect or undo any prior use or disclosure of information associated with the initial authorization.

Additional uses of information: Appointment reminders. Our staff will use your health information to remind you of pending appointments.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or on other health-related goods and services that you find to be of interest.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the above described Notice of Privacy Practice form, and I understand the rights of privacy as afforded me therein. Furthermore, I understand that reserves the right to modify the privacy practices outlined in the notice.

Name of Patient (Print)	**Date of Birth**
Signature of Patient	**Date**
Signature of Legal Guardian	**Relationship**

SHOULDER Jerry Ambrosia, M.D. **Fill out First Page ONLY**

Date: _____

Patient Name: _____ Birthdate: _____

Worker's Comp Injury? Y N Job Title: _____ Company: _____

Involved Side? R L Both Dominate Extremity: R L Ambidextrous

What happened? _____

Age: _____

How did it happen? _____

When did it start? _____

Where did it occur? _____

History (please leave this section blank)

_____

_____

_____

Previous Shoulder Treatments? None

List any Medications tried: _____

List any Therapy tried: _____

List any Injections tried: _____

Prior Shoulder Surgery: None

Date: _____

_____

Date: _____

_____

Previous Tests (MRI of Shoulder or Neck) None

MRI: Date: _____

_____

Other: Date: _____

_____

Symptoms

Pain (0 – 10) _____ Provoking Activities: _____

Pain (circle): Night Daily Constant Intermittent Overhead Activity Reaching Back

Neck pain: Y N _____ Numbness: Y N _____

SHOULDER EXAM

Right Left Both

Inspection:

Scars/Incisions/Mass: _____

Cellulitis Ecchymosis Swelling

Atrophy: Generalized SS IS Deltoid

Scapular Winging Biceps Rupture Deltoid Pull Off

Deformity: SC AC Clavicle

Palpation:

Crepitus: Subacromial GH AC Scapula

Tenderness: Biceps Deltoid AC SC Acromion GT SM Angle Coracoid

Trigger Point: Scapula Cervical

ROM: Symmetric Normal

	Right	Left
PFE	_____	_____
AFE	_____	_____
PER (0°)	_____	_____
PER (90°)	_____	_____
IR (spine)	_____	_____

Strength: Symmetric Normal

	Right	Left
Supraspinatus	_____	_____
External rotators	_____	_____
Internal rotators	_____	_____
Biceps	_____	_____

Impingement / Cuff / AC Normal

	Right	Left
Impingement	_____	_____
Painful arc motion	_____	_____
O'Brien test	_____	_____
Speed test	_____	_____
Horizontal adduction	_____	_____
Overhead adduction	_____	_____
Lift-off sign	_____	_____
Drop-arm test	_____	_____
Lag sign: ER	_____	_____
Lag sign: IR	_____	_____
Impingement test (%)	_____	_____

GH Instability Normal

	Right	Left
Anterior apprehension	_____	_____
Posterior apprehension	_____	_____
Relocation	_____	_____
Load & Shift - Anterior	_____	_____
Load & Shift - Posterior	_____	_____
Labral click	_____	_____
Reproduces symptoms	_____	_____
Ligamentous laxity	_____	_____
Sulcus sign	_____	_____
Voluntary Unstable	_____	_____

Cervical Normal Not Tested

Motion: Normal Limited: _____

Tenderness: Midline Paraspinal Trapezius

Spurlings Test: Positive Negative

Sensory: Normal Abnormal: _____

Reflexes: Normal Abnormal: _____

_____ Sensation is intact throughout the arm, forearm, wrist and hand. Patient demonstrates active elbow, wrist and hand ROM. Cap refill is brisk.

General Normal Not Tested

Lungs: Clear Abnormal: _____

Heart: RRR Abnormal: _____

Abdomen: Soft and Nontender Abnormal: _____

Skin: Normal Rash Cellulitis Abrasions Lacerations Lesions

Mental: Alert and Oriented x 3

Gait: Normal Assistive device Unable Limp

X-RAYS

Right Left Both

None taken No abnormalities X-rays from outside facility reviewed

Acromion: I II III Spur Lateral slope Thinned Previous resection Postop calcification

Os Acromiale: pre meso meta basi Fracture: _____

Acromioclavicular Joint: Normal Narrowed Arthrosis Spur Osteolysis

Sprain: I II III IV V VI

Previous resection: Partial Complete Postoperative calcification

Other: _____

Glenohumeral Joint: Normal Widened Narrowed Loose body Foreign body

OA / RA / Traumatic / CTA: Mild Moderate Severe

Subluxated / Dislocated: Anterior Posterior Superior Inferior

HHR / TSR: Cemented Uncemented

Radiolucent line glenoid: Incomplete Complete

Radiolucent line humeral: Incomplete Complete

Avascular necrosis: I II III IV

Hill-Sach Lesion ____ Bony Bankart ____ Reverse Bony Bankart _____ Bennett lesion _____

Bone loss glenoid: Anterior Posterior Inferior Superior

Bone loss humerus: Head LT GT Shaft

Osteochondral lesion: Head Glenoid Cysts: Head Glenoid

Hardware: Head_____ Glenoid _____ Shaft_____

Degenerative changes at cuff insertion site _____ Calcific Tendonitis _____

Fracture: _____

RECOMMENDATIONS

Medications/Injections:

OTC: _____

Pain: _____

NSAID: _____

Steroid: _____

Antibiotics: _____

Other: _____

Injections: Bursa AC Joint Scapula

Splint: Sling Brace Long arm splint Posterior

Therapy: PT OT Spine Modalities Ice

Tests/Studies: MRI: Shoulder Neck Humerus Scapula Contrast: Y N

CT scan: _____

X-rays: _____

EMG/NCV: _____

Blood work / Labs: _____

PPI Rating FCE Job Description

Surgery: _____

_____

_____

Follow-up:

_____ days _____ weeks _____ months PRN

MD to call Patient to call Return after test results

Referral: _____

Diagnosis: 719.41

_____

Signed _____

Jerome Ambrosia, MD