North Shore Center for Orthopedic Surgery

Name_____ D.O.B._____ Date_____
Height:_____ **Weight:**_____ **Normal Blood Pressure:**_____
Present Orthopedic Problem:_____
Email address_____

Were you injured at work? □**Yes** □**No**
Were you injured in an auto accident? □**Yes** □**No**

Medical History
Current or past medical problems_____

Have you ever had surgery? If so, what and when ?

Allergies: _____
Medications and Doses: _____

Pharmacy name and address: _____

Family History: If living, please state health. If deceased, please state cause of death and age at time of death
Father: □ living □ deceased

Mother: □ living □ deceased

Siblings: □ living □ deceased

Children: □ living □ deceased

Family History: □ cancer □ tuberculosis □ diabetes □ hemophilia □ kidney disease □ heart disease
□ allergy □ arthritis □ other_____

Review of Systems: Do you have any of the following?
Nervous System: □ Seizures □ Passing Out Episodes □ Migraines □ Other:_____
Respiratory System: □ Shortness of Breath □ Congestion □ Chest Pain □ Spitting Up Blood
Cardiac: □ Chest Pain □ Fainting □ Edema □ Palpitations □ Other:_____
Gastrointestinal: □ Appetite □ Nausea □ Constipation □ Diarrhea □ Blood in Stool □ Stomach □ Hemorrhoids
Genitourinary: □ Discharge □ Frequency of Urination □ Incontinence □ Blood in Urine □ Pain □ Other:_____
Psychiatric: □ Anxiety □ Depression □ Psychosis □ Other:_____

Smoking: □ Smoker (how long?)_____(how much?)_____
□ Former Smoker (quit when?)_____ □ Non Smoker

Alcohol Consumption: □ Never □ Rare □ Moderate □ Heavy
Are you, or could you be pregnant? □ Yes □ No □ Maybe

I hereby authorize the release of any information required to complete my medical insurance payment directly to North Shore Center for Orthopedic Surgery for surgical or medical expenses. I understand that I am financially responsible for charges not covered by this authorization/referral.

_____ _____ _____
Signature of patient *Date* *Signature of parent or guardian, if patient is a minor*

By signing below, I acknowledge reading the office Privacy Policy and consent to their use and disclosure of my protected health information for treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where they have already made disclosures in reliance on my prior consent. I consent to treatment by_____

_____ _____ _____
Signature of patient *Date* *Signature of parent or guardian, if patient is a minor*

Co-Payment at Time of Service is Required