ANDREWS INSTITUTE
ORTHOPAEDICS & SPORTS MEDICINE
An Affiliate of Baptist Health Care

CHIEF COMPLAINT FORM

Date:_____

Patient Name: _____ Preferred Name:_____

Age:_____ DOB:_____ Occupation: _____

Employer: _____

Send Note?

Referral Physician:_____ Town:_____ Y N

Primary Care Physician:_____ Town:_____ Y N

Coach/Trainer/Team Doctor:_____ School:_____ Y N

Body part being seen for: _____

Side of Body (*circle*): Right Left Body

Date Symptoms Began: _____ **Was there an injury?** Yes / No

Workers Comp? Yes / No

If "Yes", how did it happen?

_____

_____

Current Symptoms (*circle*):

Pain Swelling Catching Locking Instability Numb/Tingling

Other:_____

If there are symptoms, where are they located? _____

Are your symptoms (*circle*): Improving Worsening Stable

Are your symptoms (*circle*): Mild Mild/Mod Moderate Mod/Severe Severe

List activities or body positions making your symptoms worse (*ex. walking, running, reaching overhead*):

_____

List any prior treatment(s) for this complaint (ex. injections, surgery, physical therapy, ice):

_____

1. **ALLERGIES**: Please list any **allergies** and reactions to medications/substances in the PAST: or (*circle*) NONE

MEDICATION	REACTION	MEDICATION	REACTION
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

2. **PHARMACY**: N**ame:** _____ **Location:** _____

3. **MEDICATIONS**: Please list any **medication** you are currently taking:

MEDICATION	DOSE/FREQ	MEDICATION	DOSE/FREQ
1)		9)	
2)		10)	
3)		11)	
4)		12)	
5)		13)	
6)		14)	
7)		15)	
8)		16)	

4. **PAST MEDICAL HISTORY:** Check if you had any of these **medical problems** in the PAST: or (*circle*) NONE

ILLNESS	Y	ILLNESS	Y	ILLNESS	Y
Anemia		Heart Attack		Peripheral Vascular Disease	
Anxiety		Heart Failure		Psychiatric Illness: _____	
Asthma		Heart Murmur		Pulmonary Embolism	
Bleeding Problems		Hepatitis B		Reflux	
Blood Clot		Hepatitis C		Rheumatoid Arthritis	
Cancer: _____		High Blood Pressure		Sjogren's Disease	
Chest Pain/ Angina		HIV/AIDS		Skin Ulcer/ Breakdown	
COVID-19		Immune Deficiency		Sleep Apnea	
Deep Vein Thrombosis		Kidney Disease		Steroid Use	
Depression		Latex Allergy		Stroke	
Diabetes		Liver Disease		Thyroid Disease	
Gall Bladder Disease		Lupus		Tuberculosis- TB	
Gastric Ulcers		MRSA (resistant staph)		Urinary Infections	
Glaucoma		Neuropathy		Valve Disorders (heart)	
Gout		Osteoarthritis		Wound Healing Problem	
Heart Arrhythmia		Paralysis			

List any **other medical problems** NOT listed above:

_____
_____
_____
_____
_____
_____
_____

5. PAST SURGICAL HISTORY: Please list any **operations/surgeries** you had in the PAST: or(*circle*) NONE

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		7)	
2)		8)	
3)		9)	
4)		10)	
5)		11)	
6)		12)	

6. PAST FAMILY HISTORY: Please list major immediate **family medical problems:** or (*circle*) NONE

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

7. SOCIAL HISTORY: Please circle status use of the following:

Cigarette: Never Former Current Cigarettes per day: _____ Years: _____

Other tobacco: Never Former Current Type: _____ Years: _____

Alcohol: Never Former Current Drinks per day: _____ Type: _____

Illicit Drugs: Never Former Current Type: _____

REVIEW OF SYSTEMS: Please mark any of the symptoms you are experiencing TODAY:

GENERAL
[ ] Chills
[ ] Fever
[ ] Fatigue
[ ] Weight Loss
[ ] Other:_____

SKIN
[ ] Lesions
[ ] Itching
[ ] Rash
[ ] Varicose Veins
[ ] Skin color change
[ ] Other: _____

NOSE
[ ] Congestion
[ ] Discharge
[ ] Nose bleeds
[ ] Sneezing
[ ] Decreased sense of smell
[ ] Other: _____

EYE
[ ] Itching
[ ] Pain
[ ] Photophobia
[ ] Vision Changes
[ ] Dryness
[ ] Other: _____

EAR
[ ] Hearing Disturbance
[ ] Hearing Loss
[ ] Pain
[ ] Tinnitus
[ ] Other: _____

CARDIOVASCULAR
[ ] Chest Pain
[ ] Lower extremity swelling
[ ] Shortness breath lying down
[ ] Palpitation
[ ] Fainting
[ ] Feels faint at times
[ ] Irregular heart beat
[ ] Other: _____

MOUTH/THROAT
[ ] Difficulty Swallowing
[ ] Hoarseness
[ ] Lesions
[ ] Dental Problems
[ ] Sore Throat
[ ] Voice Changes
[ ] Dryness
[ ] Other: _____

RESPIRATORY
[ ] Cough
[ ] Shortness of breath
[ ] Coughing up blood
[ ] Wheezing
[ ] Shortness of breath at rest
[ ] Sputum production
[ ] Other: _____

GENITOURINARY
[ ] Pain with urination
[ ] Blood in urine
[ ] Sexual dysfunction
[ ] Urinary frequency
[ ] Urinary hesitance
[ ] Urinary inconsistence
[ ] Change in bladder habits
[ ] Other: _____

GASTROINTESTINAL
[ ] Abdominal pain
[ ] Constipation
[ ] Diarrhea
[ ] Nausea
[ ] Vomiting
[ ] Change in bowel habits
[ ] Heartburn
[ ] Indigestion
[ ] Stool inconsistence
[ ] Other: _____

NEURO
[ ] Confusion/ memory loss
[ ] Dizziness
[ ] Headache
[ ] Numbness
[ ] Weakness
[ ] Unsteadiness
[ ] Change in speech
[ ] Difficulty speaking
[ ] Difficulty with ambulation
[ ] Tingling
[ ] Loss of balance
[ ] Seizures
[ ] Unusual sensation
[ ] Other: _____

PSYCH
[ ] Anxiety
[ ] Depression
[ ] Hallucinations
[ ] Insomnia
[ ] Mood problems
[ ] Fearful
[ ] Suicidal ideation
[ ] Delusions
[ ] Other: _____

GYNECOLOGICAL
[ ] Change in menses
[ ] Painful Intercourse
[ ] Other: _____

MUSKULOSKELETAL
[ ] Pain in joints
[ ] Back pain
[ ] Joint swelling
[ ] Pain
[ ] Stiffness
[ ] Joint redness
[ ] Muscle pain
[ ] Joint Stiffness
[ ] Muscle weakness

HEME/LYMPH
[ ] Bleed/bruise easily
[ ] Enlarged/tender lymph nodes
[ ] Night sweats
[ ] Abnormal bleeding
[ ] Anemia
[ ] Other: _____

ENDOCRINE
[ ] Change in weight
[ ] Cold/heat intolerance
[ ] Hot flashes
[ ] Excess thirst
[ ] Excessive urination
[ ] Appetite changes
[ ] Other: _____

Patient Registration Form

Last Name:	First Name:	MI:

Social Security: _____ - ____ - _____	Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female ☐ Additional gender category or other ☐ Choose not to disclose. ☐ Female-to-Male (FTM)/Transgender ☐ Genderqueer, neither excl male or female ☐ Male-to-Female (MTF)/Transgender	Marital Status: ☐ Divorced ☐ Single ☐ Legally Sep ☐ Widowed ☐ Life Partner ☐ Unknown ☐ Married

Address:	City:	State:	Zip:

Email:

Primary Phone: (_____) _____-_____ ☐ Home Phone ☐ Cell Phone ☐ Work Phone	Secondary Phone: (_____) _____-_____ ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Preferred Language: _____

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Unknown/Decline to Answer	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Decline to Answer	U.S. Citizenship Status: ☐ U.S. Citizen ☐ Lawfully present in the U.S. ☐ Not lawfully present in the U.S. ☐ Decline to Answer

Responsible Party: This section refers to the person/party who should receive the bill

Relationship to Patient: ☐ Self (skip this section) ☐ Parent ☐ Spouse ☐ Other

Last Name:	First Name:	MI:

Social Security: _____ - ____ - _____	Date of Birth: _____/_____/_____	Gender: ☐ M ☐ F

Address:	City:	State:	Zip:

Primary Phone: (_____) _____-_____	Secondary Phone: (_____) _____- _____

New PT Paperwork

Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant ***verbal discussions*** regarding my health care. By signing this form, I permit Baptist Medical Group ("BMG") staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.

I understand that information may be released to family members or others without this form, if allowed by federal and state law.

I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.

I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.

I can update this form at any time by completing a new form and giving it to BMG staff.

I understand that BMG staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.

I understand that this is not a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

Signature	_____	
Print Name	_____	
Date	____ / ____ / _____	Time ____ : _____

Relationship to Patient

- ☐ Self
- ☐ Legal Representative or Guardian (proof of power of attorney or legal guardianship required)