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

CHIEF COMPLAINT FORM **DATE:_____**

Patient Name: _____

Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Town: _____

1. Where is your pain? Hip Knee
2. Side of Body: Right Left Both (Which is worse: R L)
3. Date Symptoms Began: _____
4. Are you using? Cane Crutches Walker
5. Was there an injury? Yes No

   If so, how did it happen?

   _____
6. Current Symptoms: Dull Sharp Ache Stabbing Throbbing
7. Are your symptoms? Improving Worsening Stable
8. Current Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
9. What activities or body positions make your symptoms worse?

   Walking Running Stairs Getting up from seat Kneeling

   Standing Lying on that side Sports: _____
10. Prior treatments?

Injections	How many	Last one	Type
R/L/ Both			Cortisone/Synvisc

Medications: Tylenol, Aleve, Ibuprofen Other pain meds:_____

Physical Therapy: _____ Bracing: _____

Modalities: Ice Heat Ultrasound Massage Acupuncture

Most relief from: _____

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**: **Name:**_____ **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:_____

8. **Review of Symptoms**: Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO
Fever/Chills		
Fatigue		
Weight loss		
Chest Pain		
Irregular Heart Beat		
Shortness of Breath		
Cough		

SLEEP APNEA SYMPTOMS	YES	NO
Do you snore loudly?		
Do you often feel tired, fatigued, or sleepy during the day?		
Has anyone observed you stop breathing during sleep?		

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____ Social Security #:_____

Address: _____ City: _____ State:_____ Zip: _____

Email:_____ Occupation: _____

Date of Birth: _____ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** _____

Race: ❑ American Indian or Alaska native ❑ Asian ❑ Black or African American

❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Unknown/Declined to answer

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown/Declined to answer

Home phone: (cell phone: (work phone: (_____

Best daytime number to reach you: ❑ home ❑ work ❑ cell Is it ok to leave a message at any of the numbers? ❑ Yes ❑ No

If no, please designate which ones, if any: _____

Primary Care Physician's Name (if applicable): _____ How did you hear about us?_____

Spouse's Name: _____ Date of Birth:_____ Spouse's SS#:_____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ❑ Self (skip to next section) ❑ Parent ❑ Spouse ❑ Other (skip to next section) _____

Last Name: _____ First Name: MI: __

Social Security Number: _____ Birth date (mm/dd/yyyy): Sex: ❑ Male ❑ Female

Address:_____ City: _____ State: _____ Zip: _____

Home phone: (_____► _____ Cell phone: ( )_____ Work phone: ( )_____

INSURANCE INFORMATION

Primary Insurance Coverage:_____ Copay: $_____

Policy effective date: _____ Deductible: $ _____ Met? ❑ Yes ❑ No If no, amount met: $ _____

Address:_____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number:_____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #:_____

Secondary Insurance Coverage: _____

Address:_____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

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#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

Signature: _____

Print Name: _____

Date: _____ Time: _____

Relationship to Patient

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