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

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Welcome! Thank you for choosing Dr. Presley to help assist you in your non-surgical sports medicine needs. The following information will help you prepare for your upcoming visit with Dr. Presley.

Appointment Date: **Appointment Time:** **Location:**

- Please complete the enclosed paperwork prior to your first appointment.
- Please arrive at least 20 minutes early so that we may verify your insurance, scan your insurance cards and photo ID, and have your chart ready for the provider to see you at your appointment time.
- If you are late, we may have to reschedule your appointment. This policy helps ensure a timely schedule for both the physician and our patients.
- If you have any outside imaging (MRI, CT, X-RAY), please bring the disc of images with the written report. We do not have access to all facilities/hospitals where you may have had your imaging performed.
- If you have not had any imaging, please arrive to your appointment 30 minutes to 1 hour early to have X-rays taken at our facility.

If you have any questions or need directions, please call us at 850.908.3180.

We appreciate the opportunity to provide you with the best care.

Dr. James C. Presley & Team

History of Present Illness

Name:_____

DOB:_____**AGE:**_____

Occupation/Job:_____

Height:_____ft **Weight:**_____lbs.

Hand Dominance:

Right-handed / Left-handed

Patient type:

New Patient / New Complaint

Body Part (Please circle):

SHOULDER / KNEE / HIP / OTHER:_____

Which side (Please circle):

RIGHT / LEFT / BOTH

SEVERITY

How severe is the pain? (0=NONE, 10=SEVERE PAIN)

AT REST:_____ AT WORST:_____

QUALITY

How would you describe the pain? (Circle all that apply):

Sharp / Dull / Aching / Throbbing

Other:_____

_____

CONTEXT

How did you injure yourself? :

No Injury- it just started hurting

Motor Vehicle Accident

Worker's Compensation Claim

Sport Injury (which sport):_____

Briefly describe the injury:

_____

_____

_____

TIMING

Is your pain: Constant Intermittent

DURATION

What is the date of injury/onset:_____

How long have you had symptoms:

_____days _____months _____years

MODIFYING FACTORS

What makes the pain better?:

_____

_____

_____

What makes it worse?:

_____

_____

_____

Describe your current limitations:

_____

_____

_____

Associated Symptoms

Circle any signs/symptoms associated with the injury:

SWELLING	STIFFNESS
POPPING	INSTABILITY
GIVING AWAY	NUMBNESS
WEAKNESS	BURNING
CATCHING	OTHER:_____

PREVIOUS EVALUATION/TREATMENT

Diagnosis (If given):_____

Have you had: XRAYS / MRI / CT Scan

Previous Treatment (PT, injections, bracing, etc.)

_____

_____

Prior surgery on the effected body part:

_____

_____

Interested in surgery if offered? YES NO

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

GENERAL	**SKIN**	**NOSE**
[ ] Chills [ ] Fever [ ] Fatigue [ ] Weight Loss [ ] Other:_____	[ ] Lesions [ ] Itching [ ] Rash [ ] Varicose Veins [ ] Skin color change [ ] Other: _____	[ ] Congestion [ ] Discharge [ ] Nose bleeds [ ] Sneezing [ ] Decreased sense of smell [ ] Other: _____
EYE	**EAR**	**CARDIOVASCULAR**
[ ] Itching [ ] Pain [ ] Photophobia [ ] Vision Changes [ ] Dryness [ ] Other: _____	[ ] Hearing Disturbance [ ] Hearing Loss [ ] Pain [ ] Tinnitus [ ] Other: _____	[ ] Chest Pain [ ] Lower extremity swelling [ ] Shortness breath lying down [ ] Palpitation [ ] Fainting [ ] Feels faint at times [ ] Irregular heart beat [ ] Other: _____
MOUTH/THROAT	**RESPIRATORY**	**GENITOURINARY**
[ ] Difficulty Swallowing [ ] Hoarseness [ ] Lesions [ ] Dental Problems [ ] Sore Throat [ ] Voice Changes [ ] Dryness [ ] Other: _____	[ ] Cough [ ] Shortness of breath [ ] Coughing up blood [ ] Wheezing [ ] Shortness of breath at rest [ ] Sputum production [ ] Other: _____	[ ] Pain with urination [ ] Blood in urine [ ] Sexual dysfunction [ ] Urinary frequency [ ] Urinary hesitance [ ] Urinary inconsistence [ ] Change in bladder habits [ ] Other: _____
GASTROINTESTINAL	**NEURO**	**PSYCH**
[ ] Abdominal pain [ ] Constipation [ ] Diarrhea [ ] Nausea [ ] Vomiting [ ] Change in bowel habits [ ] Heartburn [ ] Indigestion [ ] Stool inconsistence [ ] Other: _____	[ ] Confusion/ memory loss [ ] Dizziness [ ] Headache [ ] Numbness [ ] Weakness [ ] Unsteadiness [ ] Change in speech [ ] Difficulty speaking [ ] Difficulty with ambulation [ ] Tingling [ ] Loss of balance [ ] Seizures [ ] Unusual sensation [ ] Other: _____	[ ] Anxiety [ ] Depression [ ] Hallucinations [ ] Insomnia [ ] Mood problems [ ] Fearful [ ] Suicidal ideation [ ] Delusions [ ] Other: _____
GYNECOLOGICAL	**HEME/LYMPH**	**ENDOCRINE**
[ ] Change in menses [ ] Painful Intercourse [ ] Other: _____	[ ] Bleed/bruise easily [ ] Enlarged/tender lymph nodes [ ] Night sweats [ ] Abnormal bleeding [ ] Anemia [ ] Other: _____	[ ] Change in weight [ ] Cold/heat intolerance [ ] Hot flashes [ ] Excess thirst [ ] Excessive urination [ ] Appetite changes [ ] Other: _____
MUSKULOSKELETAL		
[ ] Pain in joints		

[ ] Back pain [ ] Joint swelling [ ] Pain [ ] Stiffness [ ] Joint redness [ ] Muscle pain [ ] Joint Stiffness [ ] Muscle weakness [ ] 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#: _____ 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*)