INTAKE

UNIVERSITY ORTHOPAEDICS AND SPORTS MEDICINE

PATIENT MEDICAL HISTORY

Name: _____ Social Security No.: _____

Birth Date: _____ Age: _____ Gender: M ____ F ____ Occupation: _____

Primary Care Physician: _____ Referred By: _____

Are you currently working? Yes ____ No ____ Where do you work? _____ How long? ____

Name of School Attending: _____ Grade: _____

Briefly describe the main reason for your visit: _____

_____

_____

Is this problem the result of an accident/injury? Yes ____ No ____ Did the accident occur at work? Yes ____ No ____

Date of injury: _____ Days off work: _____ BWC Claim #: _____

Work Status/Restrictions: _____ Attorneys Name: _____

Please list your current medications, including Aspirin, Tylenol, Ibuprofen and other over the counter medications.

Name of Medicine	Dosage		Name of Medicine	Dosage

Allergies? Yes____ No____ If yes please list: _____

Have you ever been hospitalized? Yes ____ No ____ Had an operation? Yes ____ No ____

Please list all hospitalizations and operations: _____

_____

_____

_____

_____

_____

_____

_____

Social History: Do you smoke? ____ Packs/day: ____ # of Years: ____ Do you drink? ____ Amt./day: ____

(PLEASE CONTINUE ON REVERSE SIDE)

Patient Name:_____ DOB:_____

PLEASE INDICATE BELOW WHICH HAVE BEEN PAST MEDICAL PROBLEMS FOR YOU

	Yes	No		Yes	No
Heart disease			Blood clots in your legs, lungs		
High blood pressure (Hypertension)			Neurological disease		
Lung disease (see below):			Have you ever had a stroke?		
Bronchitis			Do you have seizures?		
Emphysema			Cancer		
Asthma			Osteoporosis		
Diabetes			Osteoarthritis, degenerative arthritis		
Ulcer or stomach disease			Rheumatoid arthritis		
Kidney or bladder disease			Other medical problems, please specify:		
Liver disease					
Anemia or any blood disease					

DO YOU HAVE ANY PROBLEMS WITH ANY OF THE ITEMS BELOW? (Please answer Yes or No)

NEUROLOGIC

Thinking clearly _____
Walking _____
Weakness _____
Seizures _____
Dizziness _____

UROGENITAL

Incontinence _____
Retention _____
Urgency _____
Sexual dysfunction _____
Sexual disease _____
Other _____

GASTROINTESTINAL

Constipation _____
Other _____
(Review of Systems – 5 items and all others negative → comp)

CARDIAC AND PULMONARY

Chest pain _____
Palpitations _____
Shortness of breath _____
Heart disease _____
Other _____

MUSCULOSKELETAL

Arthralgias _____
Pain _____
Swelling _____
Limited motion _____

HEENT

Glasses _____
Visual change _____
Hearing change _____

ENDOCRINE Diabetes:_____ Thyroid disorder: _____

CANCER HISTORY _____ CONSTITUTIONAL Weight loss: _____

BLOOD DISORDER/VASCULAR _____

PSYCHIATRIC Illness: _____ Sleep disturbance: _____

Family History:_____

_____

Your current height: _____ Feet _____ Inches Your current weight: _____ pounds

Patient Signature: _____ Date: _____

BP: _____/_____ Heart Rate: _____ Respiratory Rate: _____ Temperature: _____

Physician Signature: _____ Date: _____

(Exam: (18 or more items → comp))

Revised 10.25.10

UC Health

Questionnaire

Patient Name_____
DOB_____
Visit Date_____

Communication

Primary Language __English __Spanish __French __Other

Barriers for Care __Visual __Hearing __Speech __Physical __Memory __Fears __Learning Disabilities

1. Functional Screen/Fall Risk Assessment – In the past two months, have you experienced:		
A decreased ability to walk, turn in bed, get in/out of car?	__No	__Yes
Decreased ability to care for self, perform routine tasks?	__No	__Yes
Recent problem with coordination/movement or loss of balance	__No	__Yes
Use of ambulation device such as walker/cane or crutches	__No	__Yes
Weakness, dizziness, shortness of breath, fatigue with activity	__No	__Yes
Recent frequent history of falling	__No	__Yes
Do you exercise?	__No	__Yes
If yes, what type of exercise?	_____	
If yes, how often do you exercise?	_____	
2. Nutritional Screen		
Do you eat a special diet or meal plan?	__No	__Yes
Have you had a recent weight gain or loss of 10 lbs (in the past 12 months)?	__No	__Yes
Do you have difficulty eating, chewing, swallowing or speaking?	__No	__Yes
When was the last time you were seen by a dentist?	_____	
3. Emotional /Psychosocial/Spiritual		
Do you have any spiritual, religious or cultural rituals that we need to be aware of?	__No	__Yes
Do you have any of the following?	__Sad __Trouble Sleeping	__Unexplained Crying __No Problem
Do you have current, recent thought that you would be better off dead or of hurting yourself?	__No	__Yes
Do you have a mental health provider, case manager or payee?	__No	__Yes
Do you currently receive:	__Home Health Services __Dialysis	__Home Making __Home Delivery Meals

Questionnaire

Do you have adequate resources/medications	__No	__Yes
Recent loss:	__Family (Specify) __Home Shelter __No Problem	__Job __Other
4. Abuse/Neglect		
Due to the increase in domestic violence, we ask all patients:		
Have you recently been threatened, frightened, mistreated, hurt or hit by anyone in your life?	__No	__Yes
Have you had money or other items taken from you without your permission?	__No	__Yes
5. Wellness		
Have you had the following immunizations:		
Pneumonia	__No	__Yes
Haemophilus B (Hib)	__No	__Yes
Tetanus or TDAP (within 10 years)	__No	__Yes
Hepatitis B Series	__No	__Yes
Flu (Influenza)	__No	__Yes
Other:		
None	__No	__Yes
Have you ever been tested or treated for Tuberculosis or TB	__No	__Yes
6. Educational Knowledge		
Understanding of current health problems:	__Knowledgeable	__Needs Info __On
Learning Preferences	__Listening __Reading	__Seeing __Doing
What is your highest level of school completed?		
7. Referrals		
Physician Notified	__No	__Yes
Interpreter Requested	__No	__Yes
Pharmacist	__No	__Yes
Rehab Service (PT, OT, SP)	__No	__Yes
Nutritional Services	__No	__Yes
Given social worker name and phone number	__No	__Yes
Instructed to discuss with Primary Care Provider	__No	__Yes
Completed Fall Risk Assessment	__No	__Yes
Directed to Financial Counselor	__No	__Yes
Given Dental Services Phone#	__No	__Yes
Other		

8. Other	
Comments	
Date Yearly Questionnaire Completed	

9. Patient Information	
Height:	Pharmacy Name:
Weight:	Address:
Level of Pain: 1 2 3 4 5 6 7 8 9 10	
Medication Allergies:	
	Phone:
	Fax:

UCP Physicians
Healing · Teaching · Leading

CONDIS

DISCLOSURE TO FAMILY / FRIENDS

I hereby authorize _____
(Physician / UCP Practice) to discuss the following with the person/persons listed below.

( ) Billing
( ) Condition / Treatment / Plan of Care
( ) Diagnostic Test Results
( ) Lab results

I understand that this authorization is voluntary and that it may include information relating to *AIDS, HIV infection, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse*. I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be redisclosed by such person or entity.

Allowed person / persons:

Name	Relation
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

Patient Name / Legal Representative _____

Patient DOB: _____

Signature _____ Date _____

UNIVERSITY ORTHOPAEDICS AND SPORTS MEDICINE

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In the course of my treatment my physician may prescribe a painkiller/sleeping medication. While these medications are generally safe and effective, certain guidelines must be followed in order to absolutely minimize any risk of dependency, addiction or other complications.

The guidelines are:

1. I understand that narcotics are used during an acute period (two weeks to two months). Any prescription beyond this period can put me at risk for medical issues and can best be monitored by my primary care physician or a pain clinic.

2. I am aware of the possible complications that can be masked by pain medicine. Example: fever, chills, increased pain, and swelling.

3. I will not drink alcohol, drive or operate machinery while taking this medication.

4. I agree I will not use any illegal controlled substances, including marijuana, cocaine, Heroin, etc. I agree I will not use any prescription medications obtained illegally or obtain them from friends or relatives.

5. I authorize University Orthopaedic to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.

6. I understand that if I or a family member are verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such a the local police department, drug enforcement agency, etc. as deemed appropriate for the institution.

7. My doctor dispensed a specific quantity to last me a specific amount of time. If I am told to take one pill every six hours, and instead I take two pills every six hours, I will run out before my next prescription, and I will be without this medicine for a period of time.

CONNAR

8. My doctor or his associate will refill my medicine only:
   - If I am actually due to have the medicine refilled.
   - If I keep all scheduled appointments with my doctor **and** Physical Therapy.
   - During regular office hours (8:30 a.m. – 4:00 p.m.) and **not** on weekends, holidays, or after 4:00 p.m. on weekdays.

6. If I am due for a refill before my next appointment, I should call three days ahead of time.

7. I will have the medication and any subsequent refills filled at this pharmacy:

   Name:_____ Phone Number:_____

8. I am expected to keep my medicine in a safe, secure place where the chance of theft is minimal. If my medicine is stolen, it will not be refilled before the next due date. My doctor recommends that I hide at least half of my medicine in a safe place.

9. While under the care of UC Health Orthopaedics, I will not seek or receive pain medications / sleeping pills from any other physician without the prior consent of UC Health Orthopaedics. To do so will result in these medicines no longer being prescribed.

I have read carefully, understand and agree to the above stated guidelines. Failure to comply with these guidelines may compromise my health, your ability to care for me properly, and may result in possible dismissal from care.

Patient Name	Patient Signature	Date	Date of Birth

222 Piedmont Avenue, Cincinnati, Ohio 45219 ♦ (513) 475-8690 / (513) 475-7593 Fax