CHIEF COMPLAINT

PATIENT'S NAME_____
LAST FIRST MIDDLE

Date of Birth_____ **Age**_____

Reason for seeing doctor:_____ ☐ **Left** ☐ **Right**

Did a doctor refer you for this problem? ☐ Yes, Dr._____ ☐ No

Were X-Rays/MRI taken? ☐ Yes ☐ No If "Yes", where? _____
Did you bring the X-Rays/MRI? ☐ Yes ☐ No

Did an Injury occur? ☐ Yes ☐ No If "Yes", on what date? _____

How did the injury occur? _____

***IF YOU SUSTAINED AN INJURY, DID THE INJURY OCCUR WHILE YOU WERE ON THE JOB? ☐ **Yes** ☐ **No**

How long have you had this problem? _____

FOR FEMALES: Are you pregnant? ☐ Yes ☐ No Date of last menstrual cycle: _____

DO YOU NOW HAVE?
□ SHARP PAIN
□ DULL PAIN
□ ACHING PAIN
□ PAIN ALL THE TIME
□ PAIN IN THE MORNING
□ PAIN IN THE AFTERNOON
□ PAIN AT NIGHT
□ PAIN WITH ACTIVITY/EXERCISE

IS YOUR PAIN:
□ MILD
□ MODERATE
□ SEVERE

DO YOU HAVE DIFFICULTY?
□ STANDING
□ WALKING
□ BENDING
□ SQUATTING
□ KNEELING
□ EXERCISING
□ LIFTING HEAVY OBJECTS
□ SITTING
□ GRASPING OBJECTS WITH YOUR HANDS
□ RAISING YOUR ARM ABOVE YOUR HEAD

DO YOU NOW HAVE?:
□ SWELLING AT INJURED SITE
□ PAIN RADIATING DOWN ARM OR LEG
□ SWELLING OF A JOINT
□ TINGLING OF HANDS OR FEET
□ WEAKNESS OF HANDS OR FEET
□ CATCHING OR POPPING IN JOINT
□ LOCKING OF JOINT
□ GRINDING OF JOINT

TREATMENTS YOU HAVE TRIED TO DECREASE SYMPTOMS:
□ REST □ ICE □ HEAT □ ELEVATION
□ ACE WRAP □ BRACE
□ MEDICATION: NAME
_____
□ OTHER:
_____

DID ANY OF THESE TREATMENTS HELP? □ Yes □ No
IF SO, WHICH ONES?
_____

_____ _____
SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS A MINOR) DATE

Hoffmann Orthopedic Clinic, PA
201 Oak Drive South, Suite 104
Lake Jackson, Texas 77566
F.J. Hoffmann, M.D.
979-297-3004

Receipt of Privacy Policy Statement

My signature below is for proof of receipt
of the Hoffmann Orthopedic Clinic, PA
privacy policy given to me.

Patient Name:_____

Responsible Party
Signature:_____

Home
Address:_____
_____

Relationship to Patient:_____

Date:_____

PATIENT MEDICAL HISTORY

Patient's Name: _____ **Date:** _____/_____/_____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Pulse:** _____

Medication Allergies: _____

Are you allergic to Internal or External Iodine/Betadine? Yes _____ **No** _____

Medication Name / Dosage:	Prescribing Dr.:	Reason for Taking:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy:_____ **City:**_____ **Phone:**_____

PLEASE CHECK ANY ILLNESSES THAT YOU NOW HAVE OR HAVE PREVIOUSLY HAD:

□ High Blood Pressure
□ Heart Disease
□ Heart Attack
□ Stroke
□ Poor Circulation
□ Thyroid Disease
□ Blood Disorders
□ High Cholesterol
□ Diabetes
□ Kidney Disorders
□ Pneumonia
□ Emphysema
□ Asthma
□ Peptic Ulcer Disease
□ Reflux Disease
□ Tuberculosis
□ Hepatitis □A □B □C
□ HIV / AIDS
□ Rheumatic Fever
□ Bladder Infections
□ Joint Replacement: What Joint? _____
□ Lupus
□ Arthritis
□ Blood Clot
□ Epilepsy
□ Cancer: Where? _____
□ Hay Fever / Allergies
□ Mental Illness
□ Seizures
□ Other _____

Have you ever suffered any complications from past surgeries or from general anesthesia? □ Yes □ No

Past Surgeries and Dates: _____

_____

_____

FAMILY MEDICAL HISTORY

Please identify any medical problems your BLOOD RELATIVES have or have had in the past:

□ Birth Defects
□ Asthma
□ Bone / Joint Disorders
□ Muscle Disorders
□ Skin Disease
□ Kidney Disease
□ Cancer
□ Diabetes
□ Thyroid Disease
□ Blood Disorders
□ High Blood Pressure
□ Rheumatic Fever
□ Tuberculosis
□ Seizures
□ HIV / AIDS
□ Other_____

Social History

Do you use tobacco products? Yes _____ **No** _____ If yes, how much per day? _____

Do you drink Alcohol? Yes _____ **No** _____ If yes, how much per day? _____ Per week? _____

PATIENT INFORMATION

PATIENT'S NAME _____ **SEX M F**
LAST FIRST MIDDLE

_____ _____ _____ _____ _____
AGE **DATE OF BIRTH** **SOCIAL SECURITY #** **HOME PHONE** **CELL PHONE**

MAILING ADDRESS _____
STREET OR P.O. BOX CITY STATE ZIP CODE

EMAIL ADDRESS _____

RESPONSIBLE PARTY INFORMATION IF PATIENT IS A MINOR OR STUDENT:

MOTHER'S NAME _____ MOTHER'S EMPLOYER _____

WORK PHONE _____**DOB**_____ SOCIAL SECURITY NUMBER _____

FATHER'S NAME _____ FATHER'S EMPLOYER _____

WORK PHONE _____**DOB**_____ SOCIAL SECURITY NUMBER _____

PATIENT'S EMPLOYER _____ **WORK PHONE** _____

PATIENT'S OCCUPATION _____**STUDENT? FT_____ PT_____**

JOB DUTIES _____**Sedentary Work** _____**Climbing** _____**Lifting** _____**Excessive Walking** _____**Kneeling**

EMERGENCY CONTACT _____**Relationship**_____ **PHONE** _____

*****DID THIS INJURY OCCUR AT WORK? YES _____ NO _____**

(IF INJURY OCCURRED ON THE JOB, IT WILL NOT BE COVERED BY YOUR REGULAR INSURANCE CARRIER. DR. HOFFMANN IS NOT APPROVED BY THE STATE TO SEE WORK COMP INJURIES AND THE PATIENT WILL BE RESPONSIBLE.)

Primary Insurance	**Secondary Insurance**
Name of Ins. Co.	**Name of Ins. Co.**
Insured's Name:	Insured's Name:
Insured's ID#:	Insured's ID#:
Insured's DOB:	Insured's DOB:
Insured's SS#	Insured's SS#:
Insured's Hm Phone:	Insured's Hm Phone:
Insured's Wk Phone:	Insured's Wk Phone:
Insured's Employer:	Insured's Employer:
Insured's Address: _____ _____ _____ _____ *City* *State* *Zip*	Insured's Address: _____ _____ _____ _____ *City* *State* *Zip*

MEDICAL AUTHORIZATION FOR INSURANCE AND CONSENT FOR TREATMENT

I HEREBY GIVE CONSENT FOR MEDICAL TREATMENT FOR MYSELF OR CHILD, IF MINOR. I HEREBY ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT ON THIS ACCOUNT. I HEREBY AUTHORIZE THAT INFORMATION MAY BE RELEASED TO MY INSURANCE CARRIER AND I AUTHORIZE PAYMENT DIRECTLY TO F. J. HOFFMANN, M.D. FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME UNDER TERMS OF MY INSURANCE. PAST DUE BALANCES AFTER 60 DAYS MAY BE SUBJECT TO A SERVICE CHARGE. I HEREBY AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE AS VALID AS THE ORIGINAL.

DATE _____ _____ _____
SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS A MINOR CHILD) **TEXAS DRIVERS LIC. NO.**

REVIEW OF SYSTEMS:
Are you now experiencing any of the following? (CIRCLE)

GENERAL:

Changes in Appetite	Chills	Fatigue	Fever
Headache	Dizziness	Sleep Disturbance	Weight Gain
Weight Loss	Drug Abuse	Alcohol Abuse	

ALLERGY/IMMUNOLOGY:

Blistering of Skin	Congestion	Cough	Hives
Itching of Skin	Rash	Sneezing	Watery Eyes
Wheezing			

ENDOCRINE:

Cold Intolerance	Excessive Sweating	Excessive Thirst	Weakness
Frequent Urination	Heat Intolerance	Irregular Menses	

CARDIOVASCULAR:

Chest Pain at Rest	Chest Pain w/exertion	Cyanosis	Difficulty Lying Flat
Difficulty Breathing	Swelling of Legs	Irregular Heartbeat	Palpitations
Shortness of Breath			

GASTROINTESTINAL:

Abdominal Pain	Blood in Stool	Change in Bowel Habits	Constipation
Decreased Appetite	Diarrhea	Difficulty Swallowing	Heartburn
Spitting up Blood	Nausea	Rectal Bleeding	Vomiting

WOMEN ONLY:

Breast Lump/Pain	Irregular Menses	Missed Periods
Vaginal Bleeding/Discharge		

MUSCULOSKELETAL:

Joint Stiffness	Leg Cramps	Muscle Aches	Painful Joint
Sciatica	Swollen Joints		

NEUROLOGICAL:

Difficulty Balancing	Problems with Coordination		
Gait Abnormality	Irritability	Loss of Strength	Low Back Pain
Memory Loss	Seizures	Tics	Tingling/Numbness
Loss of Vision	Tremor	Fainting	