Maryland Spine and Sports Medicine
Medical History Form

Date: _____ Patient Name: _____ SS#: _____

Please check one or more of the following reasons for your visit

Pain in the:

O Neck O Shoulder O Arm O Wrist/Hand O Back O Ankle/Foot O Hip O Leg O Headaches

O Numbness in the _____

Injury Or Date of Onset: _____/_____/_____

O Right or O Left Handed

Type of injury/symptoms: _____

O Job Accident O Slip/Fall O Sports Injury O Car Accident: O Driver O Passenger

O Other: _____

Did you go to the emergency room after the injury? O Yes O No

Did you have x-rays taken? O Yes O No

Work History:

Occupation: _____ Have you missed any work or school? O Yes O No If yes, how much time has been lost? _____ I am qualified to do the following: _____

Treatment

Since the injury, what types of treatment have you received for this condition?

Medical

Physician's Name _____ Date of first treatment: _____

Length of Treatment: _____ Medications given: _____

Chiropractic

Physician's Name: _____ Date of first treatment: _____

Length of Treatment: _____

O Adjustments O Electrical Stim O Traction O Hot/Cold Packs O Ultrasound O Massage

Physical Therapy

Facility Name _____ Date of first treatment: _____

Length of Treatment: _____

O Hot/Cold Packs O Traction O Aqua Therapy O Other_____

Surgery

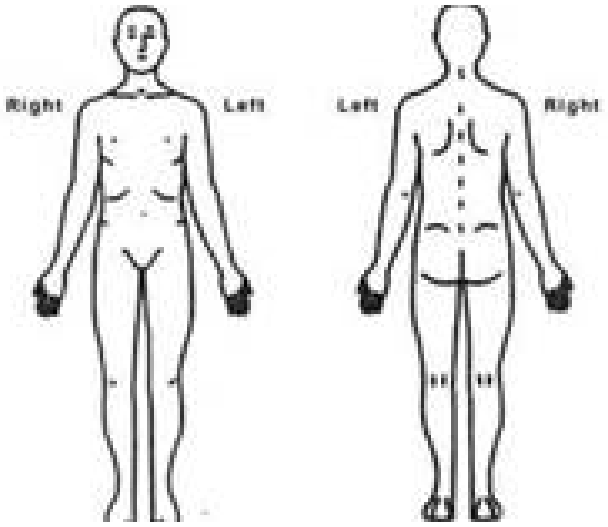
Physician's Name: _____ Date of surgery: _____

Type of surgery: _____

Pain

On these diagrams, show where you are experiencing pain and/or numbness. Please use the symbols below to describe the type of pain.

Stabbing: ///// Numbness ------ Achy AAAA Burning: XXXXX Pins and needles: ***



If you are in pain, describe your pain in detail:_____

_____

What is your pain on a scale of 1 to 10? 1 2 3 4 5 6 7 8 9 10

low pain medium pain high pain

What makes your pain worse? _____

What makes your pain better? _____

Do you have a prior history of neck or back problems or surgery? O Yes O No

Medications: Please list names of **all** medications, including over the counter medications, and dosages: _____

_____

Allergies (to medications/latex/iodine/dyes**)**: _____

Tests

What tests have you had so far relating to this condition?

Type of Test	Date	Body Part	Results
X-rays			
CT Scan			
MRI			
EMG/NSC			
Bone Scan			
Myelogram			
Discogram			
Arthrogram			

Medical Problems (check all that apply):

O Diabetes O Thyroid O Asthma O HIV/AIDS O Kidney O Stomach Ulcers O Osteoporosis O Stroke O Hepatitis

O Tuberculosis O Cancer O Arthritis O Heart problems O Rheumatoid arthritis O Seizures O Psychiatric illness

O High blood pressure O Other _____

Surgery: _____

Family History (check all that apply):

O High Blood Pressure O Cancer O Diabetes O Depression O Rheumatoid arthritis O Stroke O Heart disease

O Thyroid disease O Tuberculosis O Osteoporosis

Social History (check all that apply):

Marital status**:** O Married O Single O Divorced O Widowed

O Live in house O Live in apartment O Number of children _____ Ages: _____

Education**:** O High school O College

Cigarettes**:** O Yes O No If yes, _____ packs per day. Alcohol**:** O Yes O No If yes, _____ per week _____ years

Functional history (check all that apply):

I am not able to do the following:

O Cook O Wash the car O Twist O Clean O Lift O Laundry O Yard work O Bend O Open jars O Other: _____

I require the use of the following**:**

O Cane O Crutches O Wheelchair O Neck brace O Back brace O Splint O Other**:** _____

Review of systems (check all that apply): O Fever O Chills O Sweats O Significant weight loss O Significant weight gain

Dermatological: O Jaundice O Rash O Hives O Itching O Easily bruised

Hearing: O Deafness O Ear discharge O Ear ringing

Vision: O Glasses O Blindness O Blurred vision O See rings around lights

Pulmonary: O Shortness of breath O Wheezing O Chronic cough O Coughing up blood

Cardiovascular: O Chest pain O Varicose veins O Racing heart O Use 2-3 pillows at night O Shortness of breath w/exertion

Gastrointestinal: O Nausea O Vomiting O Diarrhea O Constipation O Blood in stool O Change in stool color O Hemorrhoids

O Difficulty feeling bowels O Difficulty controlling bowels

Genitourinary: O Blood in urine O Penile discharge O Urination at night O Pregnant O Frequent urination O Menopause

O Pelvic infections O Irregular menstruation O Urgency w/urination O Difficulty feeling urine

O Difficulty controlling urine O Difficulty w/erection O Painful menstruation O Vaginal discharge

O Vaginal bleeding O Sexually transmitted disease O Last Monthly Period: _____

Endocrine: O Thyroid enlargement O Goiter O Hyperthyroidism O Hypothyroidism

Neurological: O Headaches O Fainting O Paralysis O Balance problems O Light headedness O Dizziness O Seizures

O Memory loss O Numbness O Coordination problems

Psychological: O Trouble w/nerves O Depressed O Anxious O Suicide attempt O Difficulty sleeping O Emotional problems

Alcohol abuse/addiction: O Yes O No **Illicit drug abuse/addiction:** O Yes O No **IV drug abuse/addiction:** O Yes O No

Prescription drug abuse/addiction: O Yes O No

Maryland Spine and Sports Medicine
Patient Demographics and Insurance Information

Important Information Required for Electronic Health Records:

Pharmacy name for any prescriptions you may need? _____

City _____ Phone # _____

Smoking history (please check box): ○ Never ○ Former ○ Current.

If current, how much and are you trying to quit? _____

First Name: _____ MI: ____ Last Name: _____

Street Address: _____ City, State, ZIP: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #:_____

Date of Birth: _____ Social Security #: _____ Gender: Male/Female

Patient's Employer and Address: _____

In case of emergency, notify: _____ Daytime Phone #: _____

Primary Insurance Information

Insurance Company Name: _____ Phone #:_____

Claims Address: _____

Policy Number: _____ Group #: _____

Policy Holder Name: _____ Employer: _____

Policy Holder's Birth Date: _____ Gender: Male/Female

Relationship to Patient: _____ Social Security #: _____

Secondary Insurance Information

Insurance Company Name: _____ Phone #:_____

Claims Address: _____

Policy Number: _____ Group #: _____

Policy Holder Name: _____ Employer: _____

Policy Holder's Birth Date: _____ Gender: Male/Female

Relationship to Patient: _____ Social Security #: _____

Referring and Primary Care Physician

Referring/Primary Care Physician: _____

Phone #: _____

Insurance Authorization and Assignment(please read and sign)

I hereby authorize Maryland Spine and Sports Medicine, P.C. to furnish information to insurance carriers concerning my physical condition and treatments, and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents.I understand that I am responsible for all fees and financial charges for the above named patient, regardless of insurance coverage. If not covered by insurance, I understand that payment is required at time of service.

Signature: _____ **Date:**_____

Maryland Spine and Sports Medicine
Clark Brill, M.D., John Collins, D.O.
Aaron Twigg, M.D.

Patient Privacy Policy

IMPORTANT: PLEASE NOTE

To insure continuation of care, please provide us with the name of your referring physician, and sign the form below to authorize the release of your records.

By signing this policy, I, the patient, authorize Maryland Spine and Sports Medicine to release my records to the following physician(s) and or healthcare provider(s):

_____ _____

Physician's Name **Physician's Name**

_____

Patient Signature

_____

Print Name

It is the policy of MARYLAND SPINE AND SPORTS MEDICINE to protect the privacy of our patients to the fullest extent. In order for us to do this, we will also need the co-operation of you, our patient. The following are our attempts to be compliant with the Health Insurance Portability and Accountability Act (HIPAA).

1. All patient records are kept within the confines of this office unless there is written permission from the patient or guardian for them to be removed.
2. No records will be displayed where they are in a position to be read by any parties unrelated to their testing or treatment.
3. No records will be relayed via mail or fax unless written permission is given by the patient or guardian or it is a matter of continued medical care by his or her personal physician whom he or she has named on their "Patient History Sheet".
4. No patient records will be given to any other parties, such as attorneys or employers, without written permission from the patient or guardian.
5. We only use the most up-to-date methods for our Electronic Claims Transmission, and these relay facilities have taken every step to also be in compliance with the HIPAA regulations and have given us written notice of such actions.
6. Our staff has received instructions, both verbal and written, regarding maintaining the confidentiality of the patient and the inappropriateness of discussing personal or medical patient information outside the confines of this office.

It is our intent for these measures to protect our patients' medical information. We thank you for your attention and co-operation in this matter.