CONFIDENTIAL PATIENT CASE HISTORY

This questionnaire was designed to provide important facts regarding the history of your pain or condition. Please take the time to answer each question as completely as possible.

ARIZONA surgery consultants

1701 E. Thomas Rd. | Suite 202, Bldg. 1 | Phoenix, Az 85016
Phone 602.956.0484 | Fax 602.956.0501

First Name:_____ Last Name:_____ MI:_____

Address:_____City/State:_____Zip:_____

Phone: _____ Email Address: _____

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

Marital Status: _____ MARRIED _____ SINGLE _____ DIVORCE _____ WIDOW

Emergency Contact Name: _____ Relationship:_____Phone#:_____

How did you hear about us? _____

Please provide the name of **your auto** insurance carrier:

Carrier Name:_____ Claim/Policy: _____

Please provide the name of the **at-fault** insurance carrier:

Carrier Name:_____ Claim/Policy: _____

Name of Attorney:_____Phone #:_____

Was your injury a result of: _____ Auto Accident _____ Work Related _____ Slip & Fall _____Other

Accident Date: _____ If Auto, amount of damage to your vehicle: $_____

Police Dept. Name: _____ Police Report Number: _____

Location of Accident (cross streets or address) _____

Please describe how this accident happened: _____

_____

Your current symptoms:_____

Name of doctor(s) currently treating you for this injury?

_____

Have you ever been treated for any previous accidents? _____Yes _____No When?:_____

Have you had any of the following treatments for your current injury?

Physical Therapy	__ Yes __ No	Chiropractic Treatment	__ Yes __ No
Traction	__ Yes __ No	E-Stim/TENS Treatment	__ Yes __ No
Trigger Point Injections	__Yes __ No	Epidural Steroid Injections	__ Yes __ No

**********HISTORY & PHYSICAL**********

PAST MEDICAL HISTORY:

☐ I have no medical illnesses

☐ I have or had the following medical conditions: Check all that apply.

Cardiovascular: ☐ Hypertension ☐ Arrhythmia ☐Coronary Artery Disease ☐ Heart Murmur ☐ Other: _____

Respiratory: ☐ COPD ☐ Asthma ☐ Sleep Apnea ☐ Other: _____

Endocrine: ☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other: _____

Bleeding Disorders: ☐Anemia ☐Blood Clots ☐ Other: _____

GI: ☐Hiatal Hernia ☐Acid Reflux/GERD ☐Ulcers ☐ Other: _____

Neuro: ☐CVA/Stroke ☐Seizures ☐Parkinson's ☐ Other: _____

Infectious Disease: ☐ MRSA ☐ Hepatitis ☐ Tuberculosis ☐ HIV/AIDS ☐ Other: _____

DO YOU HAVE A PREVIOUS HISTORY OF BLOOD CLOTS? ☐ YES ☐ NO

ARE YOU TAKING ANY BLOOD THINNERS? ☐ YES ☐ NO

CURRENT MEDICATIONS:

☐ I am not currently taking any medications

☐ I am taking the following medications:

Medication	**Frequency**	**Reason for taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES:

☐ I have no known drug allergies

☐ I am allergic to the following medications:

_____

SURGICAL HISTORY: Please list ALL surgeries you have had in the past.

Type of Surgery	**Date**	**Surgeon**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any metal in your body? (Pacemakers, Aneurysm Clips, Rods, Screws, Plates, Pins, Shrapnel)

☐ NO

☐ YES. Please explain: _____

FAMILY HISTORY: Please list ANY serious family illnesses.

	List Illness Below	Are they Living?
Father	_____	☐ YES ☐ NO
Mother	_____	☐ YES ☐ NO
Brother	_____	☐ YES ☐ NO
Sister	_____	☐ YES ☐ NO
Child	_____	☐ YES ☐ NO

SOCIAL HISTORY:

Do you now **or** have you smoked cigarettes in the past? ☐ YES ☐ NO
Number of cigarettes per day: _____
Number of years smoking: _____
Do you drink alcohol? ☐ YES ☐ NO
If **YES**, how many alcoholic beverages do you consume per week? _____
Do you use illicit drugs? ☐ YES ☐ NO
If **YES**, please list: _____

REVIEW OF SYSTEMS:

General: ☐ fatigue ☐ fever, ☐ chills, ☐ night sweats ☐ weight loss
Head/ENT: ☐ headache ☐ changes in vision ☐ changes in hearing ☐ sore throat
Cardiovascular: ☐ chest pain ☐ rapid heartbeat ☐ leg swelling
Respiratory: ☐ shortness of breath ☐ cough ☐ coughing up blood
Gastrointestinal: ☐ nausea ☐ vomiting ☐ diarrhea ☐ bloody stool
Genitourinary: ☐ urgency/frequency ☐ painful urination ☐ unable to control bowel/bladder ☐ blood in urine
Neurological: ☐ weakness ☐ numbness ☐ tingling ☐ dizziness ☐ changes in sensation or speech
Psychiatric: ☐ anxiety ☐ depression ☐ insomnia
Hematological: ☐ easy bruising ☐ prolonged bleeding

I, _____, confirm that the above information is accurate to the best of my knowledge:

_____	_____	_____
PATIENT - PRINT NAME	PATIENT SIGNATURE	DATE

I have reviewed the above History and Physical information with the patient.

_____	_____	_____
PHYSICIAN – PRINT NAME	PHYSICIAN SIGNATURE	DATE

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Consent for Treatment

I hereby authorize your practice and whomever the doctor may designate as his/her assistant to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests. If any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non-complicated, I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that, the no guarantee has been made to me as the result that may be obtained.

Authorization for Release of Medical Information

This authorizes you to furnish full and complete medical information hereby requested by Arizona Surgery Consultants, LLC. This authorization includes examination of all hospital records, x-ray films, diagnostic test results, and the furnishing of all information (including, but not limited to, conferences with treating or examining health care providers). This authorization also allows the release of any and all information to Arizona Surgery Consultants, LLC concerning HIV and/or AIDS and related conditions, and psychological/psychiatric or mental health treatment. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I understand that this authorization is voluntary and at my request I may revoke this authorization at any time by notifying Arizona Surgery Consultants, LLC in writing.

Provider Name: _____

Patient Name: _____ DOB: _____

Patient or Guardian Signature: _____ Date: _____

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Notice of Privacy Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please read carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities and public health, research and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You many request restrictions on disclosures.
Disclosure of protected health information is limited to the minimum, necessary for the purpose of disclosure. The provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a request stating so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of the protected health information disclosure that is accessible to you. In the future we may contact you for appointment reminders, announcements and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about our privacy violations by contacting our office manager.

By signing below you acknowledge that you were provided a copy of this form (Notice of Privacy Practices) and that you have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. You understand that this form will be placed in your patient chart and maintained for seven years.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

_____
PATIENT'S SIGNATURE OR PARENT/GUARDIAN