PATIENT MEDICAL HISTORY FORM

PLEASE FILL OUT COMPLETELY

PATIENT'S NAME:	BIRTH DATE	AGE

REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:

OCCUPATION:

The information in this section is REQUIRED by the Federal Government and must be provided. Thank you.

HEIGHT: **WEIGHT:** **PREGNANT? ___YES ___NO**	ALCOHOL USE: ___YES ___NO HOW OFTEN :___Daily ___Wkly ___Mthly	
SMOKER: ___YES ___NO ___FORMER # PACKS/DAY:	DRUG USE: ___YES ___NO	STEROID USE: ___YES ___NO

REASON FOR VISIT:

DATE OF ONSET/INJURY:	INJURY JOB RELATED? ___ YES ___NO	AUTO ACCIDENT? ___YES ___NO

WHAT MAKES THE PAIN/PROBLEM BETTER OR WORSE?

PRIOR TREATMENT: (Surgery, Physical Therapy, Injections, Medications, Braces)

MEDICAL HISTORY (Circle all that apply - provide explanation in space provided below)

DIABETES HIGH BLOOD PRESSURE HEART CONDITIONS CANCER HEPATITIS / HIV ULCERS / REFLUX ARTHRITIS GOUT

LIST **ALL** YOUR CURRENT MEDICAL CONDITIONS:

FAMILY HISTORY (Circle all that apply - provide explanation in space provided below)

DIABETES HIGH BLOOD PRESSURE HEART CONDITIONS CANCER ARTHRITIS

LIST **ALL** YOUR FAMILY HISTORY CONDITIONS & PERSON AFFECTED:

REVIEW OF SYSTEMS/PROBLEMS (Circle all that apply - provide explanation in space provided below)

WEIGHT LOSS / GAIN FEVER / CHILLS HEADACHES EYE / VISION NECK PAIN / STIFFNESS

CHEST PAINS VARICOSE VEINS SHORTNESS OF BREATH WHEEZING /COUGHING

STOMACH PROBLEMS URINARY PROBLEMS SKIN / RASH DIZZINESS PSYCHIATRIC

EXPLAIN YOUR CONDITIONS/SYMPTOMS CIRCLED ABOVE:

LIST **ALL** YOUR PRIOR SURGERIES:

LIST **ALL** YOUR CURRENT MEDICATIONS (INCLUDE DIETARY SUPPLEMENTS, VITAMINS AND/OR DIET PILLS)

LIST **ALL** YOUR ALLERGIES / INTOLERANCES: **DO YOU HAVE A SENSITIVITY TO LATEX PRODUCTS? ___YES ___NO**

Patient / Guardian Signature	Date

Greater Hartford Orthopedic Group

HIPAA RELEASE FORM

Patient Name: _____ Date of Birth: _____

Medical Record #: _____

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends and other relations regarding not only medical treatment but also patient financials. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

Authorized Data: I request that the information to be disclosed consists of the following: Check all that apply.
Billing _____ Chart Notes _____ Radiology _____ Hospital/Surgery _____ Entire Record_____
Authorization to include all dates of service (unless time frame defined below):
From_____ to _____
Preferred method of communication: Phone _____ Mail _____
Authorization to leave message on answering machine yes _____ no_____

Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #

This authorization will expire one year from signature date.

Patient Signature _____ Date _____