



MEDICAL HISTORY ---- HISTORIAL MEDICO

NAME – NOMBRE _____ DATE – FECHA _____

Please try to answer all questions. Thank you for your cooperation.

Por favor trate de contestar todas las preguntas. Gracias por su cooperacion.

Ht – Estatura _____ Wt – Peso _____ Age – Edad _____ Occupation – Ocupacion _____

Are You? RIGHT HANDED? LEFT HANDED? AMBIDEXTROUS?
 Es Usted? MANO-DERECCHA? MANO-IZQUIERDA? AMBIDIESTRO?

ALLERGIES Please list meds or drugs you are allergic to and your reaction.

ALERGICO Por favor indique medicinas o drogas que le causen alguna reaccion alergica.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

List any anti-inflammatories you have taken and was the reaction favorable or non-favorable.

Indique cualquier anti-inflamatorio que usted haya tomado e indique si la reaccion fue favorable o no favorable.

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

CHIEF ORTHOPAEDIC COMPLAINT – PROBLEMA ORTOPEDICO MAYOR

Please list the major reason that you are seeking help here. Complaint _____

Por favor indique la razon principal que lo trajo aqui en busca de ayuda. Problema _____

Date of Onset or Injury – Fecha que empezo el problema o accidente _____

How long have you had the problem? – Por cuanto tiempo ha tenido este problema? _____

Past Treatment (Include all dates, physicians and treatments)

Ultimo tratamient (incluya fechas, doctores y tratamientos) _____

CURRENT MEDICATIONS – MEDICAMENTOS QUE ESTA TOMANDO

List all the medications you are now taking. Be sure to list all the drugs you take, including aspirin, pain meds, hormones, contraceptives, water, diet, nerve or sleeping pills and herbal supplements.

Indique todos los medicamentos que esta tomando. Este seguro de indicar todas las drogas que usted toma, incluya aspirina, medicinas para el dolor, hormonas, anticonceptivos, agua, dieta, pastillas para los nervios, para dormir o suplementos herbarios (hierbas)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

RECREATIONAL DRUGS – DROGAS RECREACIONALES

Do you use recreational drugs? If so, what kind and how often? _____

Usa drogas? Si lo Hice, que clase y con que frecuencia? _____

ALCOHOL – BEBIDAS ALCOHOLICAS

What kind, and how much alcohol do you drink? Que clase y cuantas veces tomas bebidas alcoholicas:

SMOKING – FUMAR

Do you smoke? If so, what, and how much? _____

Fuma usted? Si lo hace, que fuma y que cantidad? _____

ILLNESS AND CONDITIONS – ENFERMEDAD Y CONDICION

What illnesses and conditions are you under treatment for? (eg. Heart disease, diabetes, blood pressure, nerves)

Que enfermedades o condiciones esta usted en tratamiento? (eg. Enfermedad del Corazon, diabeteis, presion alteriar, nervios)

OPERATIONS – OPERACIONES

Operations / Dates – Operaciones / Fechas

Any Complications? - Complicaciones

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

ANESTHESIA – ANESTESIA

Have you ever had problems with anesthesia? _____

Alguna vez has tenido problemas con la anestesia? _____

HOSPITALIZATIONS (excluding operations) – HOSPITALIZACIONES (excluya operaciones)

Hospital and City – Hospital y Ciudad

Date – Fecha

Doctor

1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY HEALTH – SALUD FAMILIAR

Have any blood relatives ever had any of the following? If so, indicate their relationship to you.

Ha tenido algun familiar cercano lo siguiente? Si es asi, indique el parentezco suyo.

(e.g. Diabetes – maternal grandmother) (e.j. Diabetis – abuela materna)

Diabetes – Diabetis _____

Arthritis – Artritis _____

Tuberculosis _____

Cancer _____

Heart Trouble _____

Blood Disease- Enfermedad en la Sangre _____

Kidney Trouble – Rinones _____

Lung – Pulmones _____

Liver Trouble – Hgado _____

Psychiatric Disease _____

High Blood Pressure – Presion Arterial _____

Sickle Cell Anemia – Anemia _____

Any Unusual Disease – Enfermedad Poco Frecuente _____

Anesthesia Problems – Problemas con Anestesia _____

If your mother, father, or any of your brothers and sisters have died, what was the cause of their death?

En tu familia alguna de estas personas ha muerto y cual ha sido la causa, padres, hermanos?

NAME – NOMBRE _____

DATE – FECHA _____

REVIEW OF SYSTEMS – REVISION DE SISTEMA

	NO	YES - Date Si - Fecha
GENERAL		
Have you been losing weight? Has perdido peso?.....	_____	_____
Have you been running fevers? Has tenido Fiebre?	_____	_____
Are you on a special diet? Estas a dieta?	_____	_____
Type? Clase? _____		

EYES		
Have you ever had any of the following?		
Glasses – Espejuelos.....	_____	_____
Iritis.....	_____	_____
Glaucoma.....	_____	_____
Cataracts – Cataratas	_____	_____
Poor Vision – Vision Pobre.....	_____	_____

EARS, NOSE, MOUTH, THROAT – OIDOS, NARIZ, BOCA, GARGANTA		
Deafness – Sordera	_____	_____
Hearing Aid – Ayuda del Audio	_____	_____
Sinus Infection – Infeccion Nasal	_____	_____
Dentures – Dientes falsos	_____	_____
Gum Disease – Enfermedad.....	_____	_____
Dental Problems or Bad Teeth – Problemas Dentales	_____	_____
Jaw or Throat Problems – Problema de Quijada o Garganta	_____	_____

HEART / CIRCULATION - CORAZON / CIRCULACION		
Heart Trouble – Problemas del Corazon.....	_____	_____
Heart Murmur – Soplo de Corazon.....	_____	_____
Severe Chest Pain (angina) – Dolor de Pecho.....	_____	_____
Heart Attack – Ataque de Corazon.....	_____	_____
Heart Failure – Fallos de Corazon.....	_____	_____
High Blood Pressure – Presion Alteriar.....	_____	_____
Rheumatic Fever – Fiebre Reumatica.....	_____	_____
Varicose Veins – Venas Varicosas.....	_____	_____
Swelling of your Ankles – Inflamacion de Tobillos.....	_____	_____
High Cholesterol – Colesterol Alto.....	_____	_____
Abnormal Electrocardiogram – Electrocardiograma Anormal.....	_____	_____
Blood Clots – Sangre Coagulada.....	_____	_____
Poor Circulation – Circulacion Pobre.....	_____	_____
Taking Blood Thinners – Toma Anticoagulantes.....	_____	_____
Phlebitis – Flebitis.....	_____	_____

NO

YES - Date
Si - Fecha

RESPIRATORY / LUNGS – RESPIRATORIO / PULMONES

- Pneumonia** – Pulmonia..... _____
- Pleurisy** – Pleurisia..... _____
- Tuberculosis**..... _____
- Asthma** – Asma..... _____
- Chronic Bronchitis** – Bronquitis Cronica..... _____
- Emphysema** – Enfizema..... _____
- Other Lung Problem** – Otro Problema Pulmonar..... _____
- When was your last x-ray?** Cuando fue tu ultimo rayos x? _____
- Have you ever had an abnormal chest x-ray?** Has tenido alguna vez rayos x con problemas? _____

DIGESTIVE / STOMACH / INTESTINES – DIGESTIVO / ESTOMAGO / INTESTINOS

- Ulcer** – Ulceras..... _____
- Hiatal of Esophagus Hernia** – Hernia en el Esofago..... _____
- Vomiting of Blood** – Vomitos de Sangre..... _____
- Bloody or Tarry Stools** – Excreta con Sangre u Obscura..... _____
- Hepatitis or Yellow Jaundice** – Hepatitis o Piel Amarilla..... _____
- Liver Trouble** – Problmas del Hgado..... _____
- Gallbladder Trouble or Stones** – Problemas de vesicular o Piedras..... _____
- Persistent Diarrhea or Colitis** – Diarrea Persistente o Inflamacion del Colon..... _____
- Diverticulitis** – Inflamacion del Intestino..... _____
- Parasitic Infection** – Parasitos..... _____
- Hernia**..... _____
- Other Digestive Disease** – Otra Enfermedad Digestiva..... _____
- Abdominal Surgery** – Cirugia Abdominal..... _____

URINARY / KIDNEYS / BLADDER – URINARIO – RINONES / VEJIGA

- Bladder Infection** – Infeccion de la Vejiga..... _____
- Kidney Disease or Nephritis** – Enfermedad o Inflamacion del Rinon..... _____
- Protein or Albumin in Urine** – Proteina o Albumina en la Orina..... _____
- Blood or pus in Urine** – Sangre o Pus in la Orina..... _____
- Kidney Stones** – Piedra en el Rinon..... _____
- Prostate Trouble** – Problemas de Prostata..... _____
- How many times do you urinate at night?** Cuantas Veces orina usted de noche? _____
- Trouble Urinating** – Problemas al Orinar..... _____

ENDOCRINOLOGY ? HORMONES – ENDOCRINOLOGO / HORMONAS

- Glandular or Hormone Problems** – Problema Glandular o Hormonal..... _____
- Thyroid Disease** – Tiroide Enferma..... _____
- Diabetes**..... _____

SKIN – PIEL

- Rashes** – Alergias..... _____
- Sores** – Inflamacion..... _____
- Open Wounds** – Heridas Abierta..... _____
- Infection** – Infeccion..... _____
- Healing Problems** – Problema en Sanar..... _____

NEUROLOGICAL / NERVES – NEUROLOGICO / NERVIOS

- Frequent Headaches** – Dolores de Cabeza Frecuentes..... _____

Loss of Consciousness – Perdida de Memoria..... _____

Convulsions or Seizures – Convulsiones o Ataques..... _____

A Head Unjury – Gope en la Cabeza..... _____

Stroke – Ataques..... _____

Paralysis – Paralisis..... _____

Alzheimers or Dementia..... _____

Polio..... _____

Tremor – Temblar..... _____

Nervous Breakdown – Ataques Nerviosos..... _____

Psychiatric Condition – Condicion Psiquiatrica..... _____

Severe Depression / Nervousness – Depresion Severa / Nervios..... _____

Other Neurological Disease – Otra Enfermedad Neurologica. _____

Explain – Explica _____

Balance Problems – Problemas de Balance..... _____

Coordination Problems – Problemas de Coordinacion..... _____

HEMATOLOGY / CANCER / BLOOD – HEMATOLOGO / CANCER / SANGRE

Anemia..... _____

Bleeding or Bruising Tendency – Tendencia a Sangrar / Cardenales / Moretones

Cancer..... _____

What Kind? – Que Clase? _____

X-Ray Therapy – Terapia de Rayos..... _____

Chemotherapy – Quimoterapia..... _____

HIV or AIDS – AIDS or SIDA..... _____

Blood Transfusion – Transfusiones de Sangre..... _____

MUSCULOSKELETAL / BONES / JOINTS – ESQUELETO / HUESOS / COYUNTURA

Broken Bone Fracture – Hueso Roto o Fractura..... _____

Bone Infection – Infeccion en los Huesos..... _____

Osteoporosis – Osteosporosis..... _____

Bone Disease – Enfermedad de los Huesos..... _____

Arthritis..... _____

Joint Condition – Problema en las Coyunturas..... _____

Joint Infection – Infeccion en las Coyunturas..... _____

Ligament Injury – Golpe en los Ligamentos..... _____

Spine / Neck / Back Problems – Problemas de Columna / Cuello / Espalda..... _____

Shoulder Problems – Problemas en los Codos..... _____

Hand / Wrist – Manos / Munecas..... _____

Hip – Cadera..... _____

Knee – Rodillas..... _____

Foot / Ankle – Pies / Tobillos..... _____

OBSTETRIC / GYNECOLOGICAL – OBSTETRICO / GINECOLOGICO

Breast Tumor or Cyst – Tumor o Queste en el Seno..... _____

How many times have you been Pregnanat? Cuantas veces has estado embarazada? _____

Have you ever had Toxemia? Has tenido alguna vez Toxemia? _____

Have you ever had a hysterectomy? – Has tenido una hysterectomia? _____

Are you taking hormones or birth control pills? _____

Esats tomando hormoas o pastillas anticoncepvivas? _____

Date of Last Pap Smear? Fecha ultimo Papanicolao? _____

Are you Pregnant?– Estas embarazada?..... _____

EXERCISE – EJERCICIOS

Do you exercise?– Hace usted ejercicios?..... _____

How Often?– Frecuencia _____ **Type – Clase** _____

Name of your primary care or family doctor?Nombre doctor de familia? _____

Who referred you to this office?Quien te referrio a esta oficina? _____

Thank you!! – Gracias!!



Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Summary Privacy Notice for **Resurgens Orthopaedics**.

Privacy Notice Revision Date: April 14, 2003

Patient or Personal Representative's Name Printed

Patient or Personal Representative's Signature

Patient's Date of Birth

Personal Representative's Relation to Patient

Date

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Summary Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Summary Privacy Notice. However, acknowledgement has not been obtained because:

Patient refused to sign the Summary Privacy Notice Acknowledgement.

Patient was unable because:

There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

Other reason, describe below: _____

Employee's Name Printed

Employee's Signature

Date

Authorization to Release Protected Health Information

I, _____, hereby authorize Resurgens Orthopaedics to release my protected health information to the following: *(Please check and provide the name or specific entities to whom your protected health information may be given.)*

_____ Family members or friends: _____

_____ School or Employer: _____

_____ Other: _____

Patient or Personal Representative's Name Printed

Patient or Personal Representative's Signature

Date

There may be instances that your health care provider may wish to communicate some aspects of your protected health information via electronic means, either to you and/or another health care provider that may be consulted regarding your care or treatment. Resurgens cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk, and will allow Resurgens Orthopaedics to communicate my PHI electronically.

Yes No

This authorization shall be in effect *(please check one)*.

_____ no expiration date

_____ expiration date of _____

Patient or Personal Representative's Name Printed

Patient or Personal Representative's Signature

Date



SUMMARY OF PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstance. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader.

Right to Obtain a Paper Copy of this Privacy Summary Notice as well as the full Privacy Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and/or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager/ Privacy Leader



RESURGENS^{PC}
ORTHOPAEDICS

PAIN MEDICATION AND PRESCRIPTION REFILL POLICY

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 4:00pm will not be received until the next business day.
3. I understand that a follow-up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I am **NOT** allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.
5. Narcotics and non-narcotic medications will **NOT** be phoned in after hours or on the weekends.
6. Patients may be terminated from the practice with 30 days notice for noncompliance in the taking of their medications.
7. Resurgens will **NOT** refill prescriptions that have been lost or misplaced.
8. I must keep all appointments as recommended.
9. I will not give, trade or sell medications.
10. The following are conditions for immediate termination from the practice:
 - 1) Obtaining narcotics from any other physician while under Resurgens' care.
 - 2) Altering or forging of a prescription. *This is a felony and will be reported.*
11. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. Please be aware that if you choose to drive a vehicle you could be charged with a DUI.
12. I will not combine any narcotic medications with the consumption of alcohol.
13. Only one pharmacy may be used for filling prescriptions. My pharmacy's name and location is:
_____. (Please notify us if you change pharmacies.)

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe me pain medications.

Patient Name: _____
(Please Print)

Patient Signature: _____ **Date:** _____