

# RENAISSANCE ORTHOPAEDICS, PC

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## PATIENT INFORMATION

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

\_\_\_\_\_ CELL PHONE \_\_\_\_\_

AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ E-MAIL \_\_\_\_\_

EMERGENCY CONTACT NAME & PHONE \_\_\_\_\_

ARE YOU EMPLOYED? \_\_\_\_\_ ARE YOU RETIRED? \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_ EMPLOYER'S PHONE \_\_\_\_\_

\_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

## **IF YOU ARE UNDER 21 YEARS OLD OR THE PATIENT IS MENTALLY INCAPACITATED, PLEASE COMPLETE:**

GUARDIAN \_\_\_\_\_ GUARDIAN ADDRESS \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

PRIMARY CARE PHYSICIAN (PCP) \_\_\_\_\_ PCP ADDRESS \_\_\_\_\_

PCP PHONE \_\_\_\_\_

PCP FAX \_\_\_\_\_

NAME & PHONE # OF PHARMACY YOU PREFER TO USE \_\_\_\_\_

DO YOU HAVE PRESCRIPTION COVERAGE? \_\_\_\_\_

## INSURANCE INFORMATION

INSURANCE CARRIER \_\_\_\_\_ ID # \_\_\_\_\_

CONTACT NAME \_\_\_\_\_ PHONE \_\_\_\_\_ CLAIM # \_\_\_\_\_

**MEDICAL HISTORY**

PLEASE LIST ANY OPERATIONS YOU HAVE HAD. IF POSSIBLE, GIVE THE YEAR, NAME OF THE PROCEDURE, SURGEON, & THE HOSPITAL WHERE IT WAS DONE.

PROCEDURE	YEAR	SURGEON	HOSPITAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HAVE YOU EVER BEEN ADMITTED TO A HOSPITAL OTHER THAN FOR SURGERY? LIST THE REASON AND YEAR IF POSSIBLE:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DO YOU HAVE ANY PROBLEMS WITH ANESTHESIA? \_\_\_\_\_

DO YOU HAVE ANY FAMILY HISTORY WITH ANESTHESIA PROBLEMS? \_\_\_\_\_

PLEASE LIST ALL CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS AND ALL VITAMINS/SUPPLEMENTS

NAME	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGY INFORMATION**

	YES	NO
PENICILLIN ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>
LATEX ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>
IODINE ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE LIST ANY OTHER MEDICATION OR FOOD ALLERGIES & REACTIONS \_\_\_\_\_

DO YOU SEE A SPECIALIST (E.G. CARDIOLOGIST, LUNG DOCTOR, ETC...)? \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

PLEASE CIRCLE ALL THAT APPLY

**HEART HISTORY:**

- NO HISTORY
- HIGH BLOOD PRESSURE
- CHEST PAIN (IF YES, LAST EPISODE?)  
\_\_\_\_\_
- HEART ATTACK (IF SO, WHEN?)  
\_\_\_\_\_
- ABNORMAL HEART RHYTHM
- HEART MURMUR
- PALPITATIONS
- MITRAL VALVE PROLAPSE
- RHEUMATIC FEVER
- BYPASS SURGERY
- HEART DISEASE
- CARDIAC CATH (DATE)  
\_\_\_\_\_
- ANGIOPLASTY (DATE)  
\_\_\_\_\_
- LAST STRESS TEST (DATE)  
\_\_\_\_\_
- ECHOCARDIOGRAM (DATE)  
\_\_\_\_\_
- CONGESTIVE HEART FAILURE
- PACEMAKER/DEFIBRILLATOR
- SWELLING OF FEET, ANKLES, HAND

**RESPIRATORY HISTORY:**

- NO HISTORY
- ASTHMA
- SHORTNESS OF BREATH (REST OR ACTIVITY)
- LUNG DISEASE (OPD/EMPHYSEMA)
- CHRONIC COUGH
- COUGHING UP BLOOD
- BRONCHITIS
- PNEUMONIA
- PLEURISY
- TUBERCULOSIS
- SLEEP APNEA (CPAP/BIDAP) [WHAT SETTING?]  
\_\_\_\_\_  
\_\_\_\_\_
- BLOOD CLOTS IN LUNGS
- USE OF OXYGEN AT HOME?
- RECENT COUGH/COLD (LAST 2 WEEKS)

**KIDNEY/ENDOCRINE HISTORY:**

- NO HISTORY
- DIABETES
- THYROID DISORDER
- KIDNEY FAILURE/DIALYSIS
- PANCREATITIS
- URINARY TRACT INFECTIONS
- BLOOD IN URINE
- KIDNEY STONES
- FREQUENT URINATION
- PAINFUL/BURNING URINATION
- INCONTINENCE

**GASTROINTESTINAL/LIVER HISTORY:**

- NO HISTORY
- HEARTBURN/ACID REFLUX
- HIATAL HERNIA
- ULCER - TYPE? \_\_\_\_\_
- IRRITABLE BOWEL SYNDROME
- LOSS OF APPETITE
- CHRONIC NAUSEA/VOMITING
- CHRONIC CONSTIPATION/DIARRHEA
- RECTAL BLEEDING
- HEMORRHOIDS
- CROHN'S DISEASE
- DIVERTICULOSIS
- ULCERATIVE COLITIS
- JAUNDICE
- CIRRHOSIS
- HEPATITIS - TYPE? \_\_\_\_\_  
WHEN? \_\_\_\_\_

**PROBLEMS WITH CIRCULATION OR BLOOD FLOW:**

- NO HISTORY
- VARICOSE VEINS
- BLOOD CLOT IN LEG
- PHLEBITIS
- ANY FAMILY HISTORY OF BLOOD CLOTS? (IF YES, WHO?)  
\_\_\_\_\_
- ARE YOU CURRENTLY ON COUMADIN?  
\_\_\_\_\_
- DO YOU HAVE A HISTORY OR FAMILY HISTORY OF BLOOD CLOTS/DVT?  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE CIRCLE ALL THAT APPLY

**NEUROLOGICAL HISTORY:**

- NO HISTORY
- STROKE (CVA)
- MINI-STROKE (TIA)
- SEIZURES/EPILEPSY
- FAINTING SPEELS
- DIZZINESS/VERTIGO
- CHRONIC HEADACHES/MIGRAINES
- BRAIN TUMOR
- MENINGITIS
- SPINAL STENOSIS
- NECK (BACK PROBLEMS)
- NUMBNESS, TINGLING, WEAKNESS IN EXTREMITIES (WHERE?)  
\_\_\_\_\_
- TREMORS
- MUSCLE/NERVE DISORDERS
- HEAD INJURY
- PARALYSIS

**SKIN HISTORY:**

- NO HISTORY
- ECZEMA
- PSORIASIS
- RASH/ITCH
- OPEN SORES
- CHANGE IN SKIN COLOR

**EYES/EARS/NOSE/THROAT HISTORY:**

- NO HISTORY
- CATARACTS     RIGHT     LEFT
- GLAUCOMA     RIGHT     LEFT
- MACULAR DEGENERATION     RIGHT     LEFT
- RETINOPATHY     RIGHT     LEFT
- BLURRED/DOUBLE VISION
- WEAR CONTACTS/GLASSES
- HEARING LOSS/RINGING IN EARS
- USE EARING AID     RIGHT     LEFT
- CHRONIC EARACHES/DRAINAGE
- CHRONIC SINUS PROBLEMS/DRAINAGE
- VOICE HOARSENESS
- DIFFICULTY SPEAKING
- SWOLLEN GLANDS IN NECK
- JAW PAIN/INJURY
- TMJ
- LOOSE, CHIPPED, CAPPED TEETH

**MUSCULOSKELETAL HISTORY:**

- NO HISTORY
- ARTHRITIS
- FRACTURES?  
\_\_\_\_\_
- MUSCLE DISEASE?  
\_\_\_\_\_
- OSTEOPOROSIS
- GOUT
- ARTIFICIAL JOINT – TYPE? \_\_\_\_\_
- JOINT PAIN
- JOINT STIFFNESS/SWELLING
- CARPAL TUNNEL

**HEMATOLOGY (BLOOD) HISTORY:**

- NO HISTORY
- HIV/AIDS
- ANEMIA
- BLOOD TRANSFUSION
- SICKLE CELL TRAIT/DISEASE
- BLEEDING DISORDER
- EASY BRUISING
- BLEEDING GUMS
- NOSE BLEEDS
- BLEED EASILY OR TAKE LONG TIME TO HEAL

PLEASE CIRCLE ALL THAT APPLY

**REPRODUCTIVE (WOMAN) HISTORY:**

- NO HISTORY
- ABNORMAL MAMMOGRAM
- ABNORMAL PAP SMEAR
- BREAST CYSTS
- RIBROIDS
- COULD YOU BE PREGNANT? \_\_\_\_\_
- LAST MENSTRUAL PERIOD? \_\_\_\_\_
- ARE YOU POST MENOPAUSAL? \_\_\_\_\_

**PSYCHOSOCIAL HISTORY:**

- NO HISTORY
- ALZHEIMER'S
- ANXIETY DISORDER
- DEPRESSION
- BIPOLAR DISORDER
- MEMORY LOSS OR CONFUSION

**REPRODUCTIVE (MAN) HISTORY:**

- NO HISTORY
- ENLARGED PROSTATE
- ELEVATED PSA
- PROSTATITIS

**CANCER HISTORY:**

- NO HISTORY
- TYPE \_\_\_\_\_
- LOCATION \_\_\_\_\_
- TREATMENT \_\_\_\_\_

**IMMUNIZATION HISTORY AND LAST SHOT:**

WHEN

- FLU \_\_\_\_\_
- PNEUMONIA \_\_\_\_\_
- TETANUS \_\_\_\_\_
- SHINGLES \_\_\_\_\_

**SOCIAL HISTORY:**

DO YOU OR HAVE YOU EVER SMOKED? \_\_\_\_\_ FOR HOW MANY YEARS? \_\_\_\_\_ HOW MANY PACKS PER DAY? \_\_\_\_\_

ON AVERAGE, HOW MANY DRINKS TO YOU HAVE A WEEK?    **0**    **1-5**    **6-10**    **11-15**    **>16**

DO YOU OR HAVE YOU EVER USED RECREATIONAL (STREET) DRUGS? \_\_\_\_\_

IF YES, WHAT? \_\_\_\_\_ LAST USE? \_\_\_\_\_

**PAIN HISTORY (FOR YOUR KNEE OR HIP):**

LOCATION: \_\_\_\_\_

FOR HOW LONG (YEARS/MONTHS)?: \_\_\_\_\_

DOES THE PAIN RADIATE?: \_\_\_\_\_ IF SO, WHERE?: \_\_\_\_\_

WHAT MAKES THE PAIN WORSE?: \_\_\_\_\_

WHAT MAKES THE PAIN BETTER?: \_\_\_\_\_

RATE THE PAIN. WHAT IS IT MOST OF THE TIME?    1    2    3    4    5    6    7    8    9    10  
(SLIGHT ..... MODERATE ..... SEVERE)

WHAT KIND OF PAIN IS IT?:     SHARP     DULL     ACHING     BURNING

ANY PREVIOUS INJURIES/SURGERIES TO YOUR JOINT?: \_\_\_\_\_

**SOCIAL WORK ASSESSMENT**

**YOUR HOME ENVIRONMENT:**

WHO LIVES WITH YOU? \_\_\_\_\_ ARE THEY HEALTHY AND ABLE TO ASSIST YOU? \_\_\_\_\_

WHO CAN HELP YOU AFTER SURGERY? (LOCAL, FAMILY, & FRIENDS) \_\_\_\_\_

DO YOU HAVE ANY CONCERNS SUCH AS FAMILY, FINANCES, HOUSING, MENTAL HEALTH AND/OR DOMESTIC VIOLENCE?

YES       NO      OTHER \_\_\_\_\_

DO YOU HAVE ANY PROBLEMS COMMUNICATING? IF YES, EXPLAIN \_\_\_\_\_

HAVE YOU HAD JOINT REPLACEMENT BEFORE?       YES       NO

- IF YES, WHICH JOINT/SIDE & WHEN? \_\_\_\_\_

DID YOU RETURN HOME AFTER SURGERY?       YES       NO

- IF NOT, WHERE DID YOU GO? \_\_\_\_\_

**STEPS:**

EXTERIOR ON APPROACH:     NONE      \_\_\_\_\_ NUMBER OF STEPS      RAILINGS?       YES       NO

INTERIOR BASEMENT TO 1<sup>ST</sup> FLOOR:     NONE      \_\_\_\_\_ NUMBER OF STEPS      RAILINGS?       YES       NO

INTERIOR 1<sup>ST</sup> FLOOR TO 2<sup>ND</sup> FLOOR, ETC:     NONE      \_\_\_\_\_ NUMBER OF STEPS      RAILINGS?       YES       NO

WILL YOU HAVE ASSISTANCE USING THE STAIRS IMMEDIATELY AFTER SURGERY?     YES       NO

1<sup>ST</sup> FLOOR BATHROOM/POWDER ROOM    ?     YES       NO      1<sup>ST</sup> FLOOR BEDROOM?       YES       NO

PLEASE CIRCLE STYLE OF YOU HOME:    APT.    CONDO/TOWNHOUSE    SPLIT LEVEL    1 STORY    2 STORY    OTHER \_\_\_\_\_

**MEDICAL EQUIPMENT:**

CIRCLE ANY OF THE FOLLOWING EQUIPMENT YOU ALREADY OWN: (CANE    WALKER    WHEELCHAIR    BEDSIDE TOILET    SHOWER CHAIR    CRUTCHES    RAISED TOILET SEAT    STAIR GLIDE    CHAIRLIFT    OTHER \_\_\_\_\_)

DO YOU DRIVE?       YES       NO      IF NOT, WHO TRANSPORTS YOU? \_\_\_\_\_

ARE YOU INDEPENDENT WITH ACTIVITIES?     YES       NO

DO YOU USE COMMUNITY RESOURCES SUCH AS: (MEALS ON WHEELS    LIFELINE    ACCESS TRANSPORTATION    PRIVATE CAREGIVERS    AREA AGENCY ON AGING    OTHER \_\_\_\_\_)

ARE YOU INTERESTED IN INFORMATION REGARDING ANY OF THE ABOVE?     YES       NO

**HOME CARE AGENCY PREFERENCE:**

NO PREFERENCE     UPMC    OTHER \_\_\_\_\_

DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL/POWER OF ATTORNEY)?     YES       NO

- IF YES, BRING IT WITH YOU THE **DAY OF SURGERY**

- IF NO, WOULD YOU LIKE TO RECEIVE INFORMATION?     YES       NO

**FAMILY MEDICAL HISTORY:**

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
SIBLINGS	_____	_____	_____
	_____	_____	_____
SPOUSE	_____	_____	_____
CHILDREN	_____	_____	_____

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**PLEASE READ AND SIGN THE INSURANCE AUTHORIZATION**

**COMMERCIAL INSURANCE:** REQUIRED FOR ALL COMMERCIAL CARRIERS EXCLUDING WORKMAN’S COMPENSATION AND AUTO CARRIERS:

I AUTHORIZE RENAISSANCE ORTHOPAEDICS, P.C. TO RELEASE TO MY INSURANCE COMPANY ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIM. I HEREBY AUTHORIZE PAYMENT TO RENAISSANCE ORTHOPAEDICS, P.C. OF ANY BENEFIT DUE ME UNDER MY INSURANCE PLAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR NON-COVERED CHARGES. THIS AUTHORIZATION OR COPY OF IT SHALL BE VALID FOR 12 MONTHS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICARE AUTHORIZATION:**

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION OR OTHER INFORMATION TO PROVIDE TO THE MEDICARE PROGRAM AND/OR ANY OF MY INSURANCE CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED CLAIM. I REQUEST PAYMENT BE MADE DIRECTLY TO THE PROVIDER.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_