



Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First M.I. Last

Which shoulder hurts?  Right  Left  Both  
 Hand dominance  Right  Left  Ambidex  
 Date of injury or onset of symptoms? \_\_\_\_\_ Worker's comp injury?  Yes  No  
 Was the onset acute or gradual? \_\_\_\_\_ Motor vehicle accident?  Yes  No  
 Do you have neck pain?  Yes  No \_\_\_\_\_  
 Have you had a prior injury?  Yes  No Have you seen anybody else?  Yes  No Who: \_\_\_\_\_

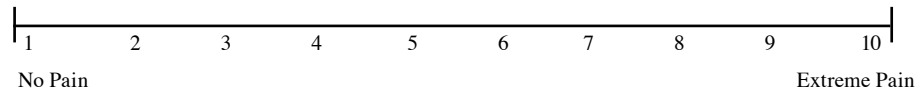
Describe your injury: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

My main problem is:  Pain  Weakness  Stiffness  Locking  Instability  
 (Instability means feelings of bones coming out of joint or shifting on each other.)  
 My shoulder catches (doesn't move freely for several seconds)  Yes  No

At the time of injury:  
 did you feel/hear a pop?  Yes  No  
 did you have swelling?  No  Immediately  Within a few hours  Overnight

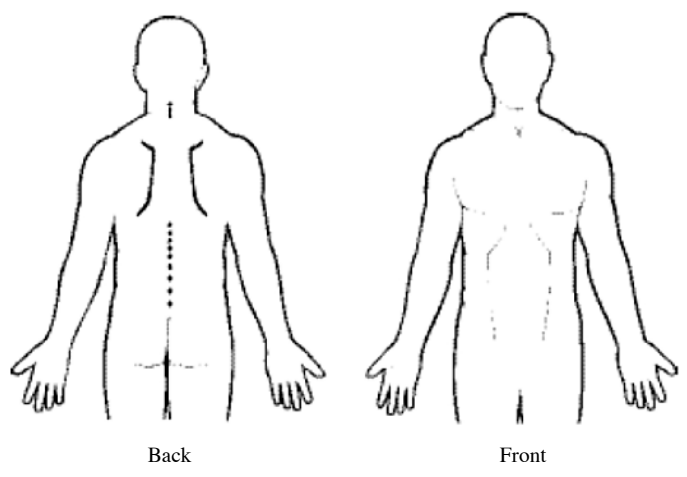
Describe your pain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Circle your pain level on a scale of 1 to 10, with 10 being unbearable, or worst imaginable, pain.



Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

- Stabbing pain /////  
 Burning pain oooo  
 Aching pain xxxx  
 Numbness =====



Reviewed by: \_\_\_\_\_, MD  
 Date: \_\_\_\_\_

**Health History Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

List all past medical problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all current medical problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently pregnant or do you think you are pregnant?  Yes  No

List all current medications:(including over-the-counter and herbal/supplements) \_\_\_\_\_

What medications have you tried in the past: \_\_\_\_\_

List all DRUG ALLERGIES including adverse reactions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Systems**

Are you currently having or have you had problems with your:

	Check	Describe all yes responses
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Ears, Nose, Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lungs, Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Digestion/Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bowel movement	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart problems/Chest Pain (including rheumatic fever)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bleeding problems/Blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Balance problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Numbness/tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Blackout/fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Psychological problems/Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
AIDS/Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis/rheumatoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Weight loss/weight gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Migraines or headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Skin, e.g., rashes, lesions, moles	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____



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**Past Surgical History**

Have you ever had any problems with anesthesia?  Yes  No Explain: \_\_\_\_\_

Surgery	Year	Complications

**Family History**

Do any of your grandparents, parents, siblings, or children have any of the following diseases? Please explain.

- Diabetes  Yes  No \_\_\_\_\_
- High blood pressure  Yes  No \_\_\_\_\_
- Heart attack  Yes  No \_\_\_\_\_
- Cancer  Yes  No \_\_\_\_\_
- Arthritis  Yes  No \_\_\_\_\_
- Rheumatoid arthritis  Yes  No \_\_\_\_\_
- Back or neck problems  Yes  No \_\_\_\_\_
- AIDS/HIV  Yes  No \_\_\_\_\_
- Bleeding disorders  Yes  No \_\_\_\_\_
- Epilepsy  Yes  No \_\_\_\_\_
- Hepatitis  Yes  No \_\_\_\_\_
- Migraines/headaches  Yes  No \_\_\_\_\_
- Psychiatric problems  Yes  No \_\_\_\_\_
- Stomach  Yes  No \_\_\_\_\_
- Thyroid problems  Yes  No \_\_\_\_\_

**Social History**

- Marital status:  Single  Married  Divorced  Separated  Widowed
- Do you live alone?  Yes  No
- Employed (occupation \_\_\_\_\_)  Student  Retired
- Children?  Yes  No Number: \_\_\_\_\_
- Exercise?  Never  Rarely  Weekly  Daily
- What type of exercise? \_\_\_\_\_
- Smoking?  Yes  No \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.
- Quit smoking?  Yes  No When? \_\_\_\_\_
- Previously smoked?  Yes  No \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.
- Chew tobacco?  Yes  No How much? \_\_\_\_\_
- Drink alcohol?  Yes  No How much and how often? \_\_\_\_\_
- Substance abuse?  Yes  No What? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

MD Signature \_\_\_\_\_ Date \_\_\_\_\_



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What makes your pain better? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What makes your pain worse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have trouble with your activities of daily living? (putting on shoes/socks, cooking, laundry, bathing, etc)  No  Yes Explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have difficulties at work?  No  Yes Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are overhead activities worse?  No  Yes  
Have you noticed weakness?  No  Yes  
Do you have any numbness or tingling?  No  Yes

What are the hobbies/sports that you participate in? \_\_\_\_\_

Does your pain limit your participation in these?  No  Yes How? \_\_\_\_\_

Do you have pain at rest?  No  Yes  
Do you have pain at night?  No  Yes  
Have you taken any medication for the pain?  No  Yes List, \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you tried anything else for the pain?  No  Ice  Brace  Therapy  Other \_\_\_\_\_

Have you had steroid injections in your shoulder?  Yes  No Number \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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**Durango Orthopedics Associates, P.C.**

**Patient Registration and Consent for Medical Treatment**

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Durango Orthopedic Associates, P.C.
  
2. **Authorization for Release or Information:** Durango Orthopedic Associates, P.C. and my physician may release information from my medical records to any health care provider involved in my care and treatment, including Mercy Medical Center. Durango Orthopedic Associates, P.C. and my physician may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare/Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Durango Orthopedic Associates, P.C. is no longer responsible for the confidentiality of any information known or possessed by the payer.
  
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Durango Orthopedic Associates, P.C. and of my physician, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from Durango Orthopedic Associates, P.C., I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Durango Orthopedic Associates, P.C.
  
4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Durango Orthopedic Associates, P.C. charges.
  
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Durango Orthopedic Associates, P.C. and my physician for charges not paid.

**I acknowledge that:**

I have read this form and understand its contents

I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms

**I am responsible for the payment and/or co-payment that is due at the time of service**

\_\_\_\_\_  
Signature of Patient or Legally Responsible Person

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Relationship/Reason Why Patient is Unable to Sign

\_\_\_\_\_  
Date