Orthopaedics & Sports Medicine
TEMPLE HEALTH

Date _____ **New Patient History Form**

Patient Name _____ Email _____ DOB _____

Height ___ft ___in Weight _____lbs □Male □Female □Right-Handed □Left-Handed

Occupation _____ Primary Care Physician _____

Referred By/How Did you Find this Doctor_____

Reason for Today's Visit/Chief Complaint:_____ □**Right** □**Left** □**Both** How Long has this been a problem? _____

Did you Have an Injury? □Yes □No If Yes, Date of Injury/Describe Injury_____

Work Related? □Yes □No

Are You Experiencing Any of the Following (Please Check)

□ Pain □ Swelling □ Redness □ Limited Motion □ Muscle Weakness □ Loss of Muscle

□ Popping □ Locking/Catching □ Stiffness □Numbness/Tingling □ Mass □ Deformity

Have You Been Treated for this Problem Before? □ Yes □ No

What Kind of Treatment? □ Medication □ Injection □ Splint/Brace □ Therapy □ Surgery □ Xray/MRI □ Nerve Test

□ Other _____

Have you ever taken Steroid Medications (Cortisone, Prednisone, etc)? □ No □ Yes (List) _____

Do You Have Any Allergies to Medications? □ No □ Yes (List) _____

Please list ALL Medications/Supplements/Herbs Taking:

MEDICATION NAME	DOSE/FREQUENCY

MEDICATION NAME	DOSE/FREQUENCY

Tobacco Use □ Never Smoker □ Former Smoker □ Current Smoker Type and Amount/Day _____

Chew Tobacco □ No □ Yes **Caffeine Use** □ No □ Yes Frequency/Type_____

Alcohol Use □ No □ Yes Frequency _____

Street Drugs □ No □ Yes Type_____ **Exercise** □ No □ Yes (Type/Freq) _____

Do You Play Sports? □ No □ Yes: What Sport _____ Position _____

What Level Of Sport? □ Highschool □College □ Other _____

Where do you go to School? _____

Have you Ever Had Surgery? □ No □ Yes Please List **ALL** Surgeries (Include Date): _____

_____

Health History: Please Mark/Indicate any Illness/Condition YOU or your Immediate Family Members have had:

	YOU	Relative
Diabetes		
Liver Trouble		
Blood Clot/Stroke		
Cancer		
Arthritis		

	YOU	Relative
Psychiatric Disease		
High Blood Pressure		
Unusual Reaction Anesthesia		
Sudden Death		
Other (Identify)		

Have you had gastric bypass surgery/sleeve? □ No □ Yes Do You Have Diabetes? □ No □ Yes If Yes Most Recent A1C: _____

Females Only:

Are You Pregnant? □ No □ Yes Have You Had A Baby within the Last Month? □ No □ Yes

Do you take Birth Control? □ No □ Yes How Long? _____ Are you on Hormone Therapy? □ No □ Yes _____

Temple Orthopaedics and Sports Medicine

REVIEW OF SYSTEMS - REVISION DE SISTEMAS

Patient's Name / Nombre del paciente: _____

If you have any of these symptoms, check "yes" and circle the symptom. If not check "no"
Por favor marque "sí" de tener alguno de estos síntomas y haga un círculo alrededor del mismo. De no tenerlos, escoja NO.

General (fatigue, weakness, weight loss, fevers) Sistema en general (cansancio, debilidad, pérdida de peso, fiebre)	YES / SÍ	NO
Allergies/ Immunologic (frequent infections, hives) Alergias/ Inmunológico (infecciones frecuentes, ronchas)	YES / SÍ	NO
Skin (rash, ulcer, dryness, nail changes) Piel (sarpullido, úlceras, resequedad, cambios en las uñas)	YES / SÍ	NO
Eyes (blurred vision, redness, tearing, glasses) Ojos (visión borrosa, enrojecimiento, lagrimeo, espejuelos)	YES / SÍ	NO
ENT (impaired hearing, ringing, sore throat) Ojos, nariz, garganta (impedimento auditivo, zumbido, dolor de garganta)	YES / SÍ	NO
Pulmonary (shortness of breath, coughing, wheezing) Pulmonar (dificultad para respirar, tos, sibilancia)	YES / SÍ	NO
Cardiovascular (chest pain, palpitations, ankle swelling) Cardiovascular (dolor de pecho, palpitaciones, edema (hinchazón) de los tobillos)	YES / SÍ	NO
Genital (discharge, irregular menses, etc.) Genital (secreciones, menstruacción irregular, etc.)	YES / SÍ	NO
Urinary (pain, frequency, incontinence, bleeding) Urinario (dolor, frecuencia, incontinencia, sangrado)	YES / SÍ	NO
Neurologic (headaches, dizziness, weakness, numbness) Neurológico (dolor de cabeza, mareos, debilidad, adormecimiento)	YES / SÍ	NO
Endocrine (heal/cold intolerance, blood sugar) Endocrino (intolerancia al frío o al calor, azúcar en la sangre)	YES / SÍ	NO
Hematologic / Limphatic (lymph nodes, bleeding problems, clots) Hematológico / Linfático (nódulos linfáticos, problemas de sangrado, coágulos)	YES / SÍ	NO
Psychiatric (depression, anxiety) Psiquiátricos (depresión, anxiedad)	YES / SÍ	NO
Gastrointestinal (nausea, vomiting, stomach pain, heartburn, diarrhea) Gastrointestinal (nausea, vómitos, dolor de estómago, acidez, diarrea)	YES / SÍ	NO
ALLERGIES TO MEDICATIONS (Please print) ALERGIAS A MEDICAMENTOS (Por favor use letra de imprenta):		

Orthopaedics & Sports Medicine
TEMPLE HEALTH

PATIENT NAME: _____

DATE: _____

TEMPLE UNIVERSITY ORTHOPAEDICS & SPORTS MEDICINE FINANCIAL POLICY/SIGNATURE ON FILE

I REQUEST PAYMENT OF AUTHORIZED MEDICARE AND/OR OTHER INSURANCE BENEFITS BE MADE ON MY BEHALF TO THE TEMPLE UNIVERSITY MEDICAL PRACTICES PHYSICIAN FOR ANY SERVICE FURNISHED TO ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND/OR OTHER INSURANCE CARRIER AND THEIR AGENT ANY INFORMATION NECESSARY TO DETERMINE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY NON-COVERED SERVICES, DEDUCTIBLES, CO-PAYMENTS AND/OR CO-INSURANCES NOT COVERED BY MY INSURANCE.

X _____

PATIENT/PARENT OR GUARDIAN SIGNATURE

_____

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

THIS IS TO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE TEMPLE UNIVERSITY HEALTH SYSTEM NOTICE OF PERSONAL HEALTH INFORMATION PRIVACY PRACTICES (HIPAA).

X _____

PATIENT/PARENT OR GUARDIAN SIGNATURE

_____

DATE

THIS IS TO ADVISE MY PHYSICIAN THAT I GIVE PERMISSION FOR YOU TO SHARE ANY AND ALL INFORMATION CONCERNING MY MEDICAL CONDITIONS WITH:

NAME(S): _____

RELATIONSHIP TO PATIENT: _____

MY SIGNATURE ON THIS DOCUMENT GIVES YOU PERMISSION TO SPEAK WITH AND DISCUSS MY CARE WITH THESE DESIGNATED PERSON(S).

X _____

PATIENT/PARENT OR GUARDIAN SIGNATURE

Orthopaedics & Sports Medicine
TEMPLE HEALTH

PATIENT NAME: _____

DATE: _____

CONSENT FOR TREATMENT & REVIEW OF PATIENT RESPONSIBILITIES

I authorize the physician and staff of Temple Orthopaedic Surgery to provide treatment for my medical ailment.

I understand the treatment offered will not always correct my ailment and can even result in adverse complications. In addition, I understand that the best outcome requires me to diligently follow the prescribed treatment plan. Adverse outcomes can result from missing office appointments, missing physical therapy appointments, not appropriately taking prescribed medications, not properly caring for or inappropriately weight-bearing in casts/splints, and not following the treatment regimen in general as outlined by the physician. I understand every effort will be taken by both the physician and I in a spirit of joint cooperation to improve my medical ailment.

I understand that cast/splinting may be necessary in the treatment of my ailment. Adverse affects from the use of cast/splints can include severe injury to skin. This can occur during cast/splint application, during immobilization within the cast/splint and its removal. Additional adverse affects from cast/splinting include but are not limited to nerve parasthesias/palsies/dystrophy, tendon irritation, and joint stiffness. In addition, casting/splinting can result in compartment syndrome with the risk of loss of life and limb. I understand that I am responsible to notify the physician of any symptoms such as pain out proportion, change in temperature, color, sensation, and function of the limb immediately to the physician so intervention may be initiated.

I understand that medications may be necessary in the treatment of my ailment. All medications have the risk of adverse complications. In particular, narcotic medications, non-steroidal anti-inflammatory medications, and antibiotics have a high risk of complications such as constipation, stomach upset, nausea/vomiting, gastrointestinal bleeding, cardiovascular risks, and allergic reactions. In addition, I understand that severe life threatening injury can occur if these medications are taken while operating machinery, not taken as prescribed, taken with other substances (such as other narcotics, alcohol, or illicit drugs), or if taken by someone other than the person it is prescribed to. In addition, I understand I am responsible for reviewing and understanding the details of the mediation's adverse reactions as provided by a pharmacist.

I understand that injections may be necessary in the treatment of my ailment. Adverse affects from injections include pain, infection, bleeding, nerve injury, tendon injury, and injury to the surrounding structures. In additional medications included within the injection can cause allergic reaction, atrophy, elevated blood glucose levels, and skin depigmentation.

I understand that surgery may be necessary in the treatment of my ailment. Risks and benefits will be provided in detail on a separate consent form.

I acknowledge that the information provided above has been satisfactorily explained to me and that I fully understand each provision. I further acknowledge that I have been given an opportunity to ask questions that I might have concerning the treatment of my ailment and associated risks, as well as any alternative courses of treatment and associated risks. Further, I certify that I have been provided all information that I have requested.

I have read and understand this consent for treatment and hereby GIVE MY CONSENT AND AUTHORIZATION FOR EVALUATION AND TREATMENT.

PATIENT NAME:	**DATE:**

X _____

PATIENT/PARENT OR GUARDIAN SIGNATURE

_____

WITNESS

Orthopaedics & Sports Medicine
TEMPLE HEALTH

PATIENT NAME: _____

DATE: _____

POLICY ON NARCOTIC DRUG PRESCRIPTIONS

Due to the increasing rate of narcotic dependence and abuse nationwide, the Department of Orthopaedic Surgery & Sports Medicine at Temple University has developed a Narcotics Prescription Policy limiting the use of these drugs in accordance with guidelines developed by your insurance, the Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA). ***Please read this document carefully as this policy will be strictly enforced.***

1. The physicians in our department will prescribe narcotic (opioid) pain medication for acute pain related to your surgery. Strength and duration of the medication will be defined at the discretion of the surgeon. No extended or sustained release medications will be prescribed. If you continue to need assistance with pain management after you have finished your course of therapy, you will need to contact your primary care physician or ask for a referral to a pain management specialist.

2. In the event a non-operative treatment plan has been recommended, pain management can be rendered either by your primary care physician or by the non-surgical specialist to whom you are referred to for further care.

3. Our physicians are required by law to access the PA Department of Health ***Prescription Drug Monitoring Program website*** before prescribing any controlled substance, opioid or narcotic. If we discover that you are receiving narcotic pain medication from more than one physician, the prescribing of such medication by our department will be immediately suspended and you may be discharged from care.

4. In the event of suspected narcotic abuse, further prescriptions of narcotic pain medications will not be made. In the event of documented narcotic abuse, further prescriptions will not be made and you may be discharged from care. ***If you need assistance in finding a provider or funding for addiction treatment, please call 1-800-662-HELP (4357).***

5. Altering or forging a prescription is a felony and will be reported to the appropriate authorities. It is also a condition for immediate termination of care from our practice.

6. Narcotic refills will NOT be provided/phoned in after regular business hours (8am-5pm) or on weekends and holidays.

7. You are required to be responsible with your prescriptions. Lost, damaged, stolen or misplaced narcotics prescriptions will NOT be replaced.

If you feel that your symptoms are an emergency, you should seek immediate medical attention at the nearest emergency room.

This policy has been created to insure the health and safety of our patients. By reading and signing this policy, you agree to the terms listed above. If you do not agree, we would be happy to assist you in finding a provider who is better able to meet your needs.

X _____

PATIENT/PARENT OR GUARDIAN SIGNATURE