Name:

Chart:

Date:

PATIENT MEDICAL HISTORY

Name: _____ DOB: _____

Referring Physician: _____ PCP: _____

Reason for visit: _____

Cause of problem: ____ Car accident ____ Work Accident ____ Other _____

Date of onset: _____ Current symptoms: _____

Occupation: _____

Are you currently disabled from work? YES / NO

The date you last worked: _____

Any work restrictions? Lifting, time, etc. please explain: _____

Marital status: _____ Children: _____

Do you smoke: YES / NO How many packs/day? _____ How long? _____

When did you quit? _____

Do you drink alcohol? YES / NO If yes, DAILY / WEEKLY / MONTHLY / RARELY

Any history of drug use? YES / NO

Do you live alone? YES / NO If no, who lives with you? _____

Do you need to go up and down stairs? YES / NO How many? Do you have railings? YES / NO

Is your bedroom on 1st floor? YES / NO Is your bathroom on 1st floor? YES / NO

Do you have throw rugs? YES / NO / NA Night lights? YES / NO / NA

Do you have grab bars? YES / NO / NA

Do you have adaptive equipment?

____ Cane ____ walker ____ wheelchair ____ beside commode ____ raised toilet ____ reacher ____ braces

MEDICAL INFORMATION

Please list current medications and dosages; prescription and over the counter: _____

Any allergies to medications? YES / NO List the medications and reaction: _____

Please circle any problems you have currently or had in the past:

GENERAL: fever, weight loss, fatigue, night sweats	CURRENT	/	PAST
EYES: injuries, glaucoma, cataracts, macular degeneration	CURRENT	/	PAST
EAR, NOSE, THROAT, MOUTH: hearing loss, hearing aides, ear pain, ringing in the ears, vertigo, nosebleeds, nasal congestion, inability to smell, sinus problems, sore throat, mouth sores, Meniere's disease, tonsillectomy	CURRENT	/	PAST
CARDIOVASCULAR: heart attack, angina, heart murmur, irregular pulse high cholesterol, bypass surgery - heart or legs, leg pain while walking, swelling, congestive heart failure, high blood pressure, DVD, pulmonary embolism	CURRENT	/	PAST
RESPIRATORY: asthma, COPD, emphysema, cough, shortness of breath, pneumonia, lung cancer	CURRENT	/	PAST
GASTROINTESTINAL: reflux, indigestion, ulcers, colon cancer, abdominal pain, liver disease, jaundice, bowel problems	CURRENT	/	PAST
GENITOURINARY: kidney stones, bladder infections, urinary incontinence, prostate cancer, endometriosis, cervical or uterine cancer, breast cancer/surgeries	CURRENT	/	PAST
MUSCULOSKELETAL: Neck pain, low back pain, arthritis, joint replacement, weakness, joint pain, fractures, Lyme disease, rheumatoid arthritis	CURRENT	/	PAST
NEUROLOGICAL: headaches, dizziness, numbness or tingling hands/feet, weakness, balance problems, memory problems, spinal cord injury, head/brain injury, stroke, MS, seizure, fainting/passing out, coordination issues, speech, arm/leg pain or burning	CURRENT	/	PAST
SKIN: cancer/eczema/psoriasis/pressure sores	CURRENT	/	PAST
ENDOCRINE: diabetes/thyroid	CURRENT	/	PAST
PSYCHIATRIC depression/anxiety/bipolar/other	CURRENT	/	PAST
PAST SURGERIES: please list type and year if known _____	CURRENT	/	PAST

(for office use) Height_____ Weight_____ B/P_____ BMI_____ Age_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

MEADVILLE MEDICAL CENTER | MORE THAN A HOSPITAL
1034 Grove Street
751 Liberty Street
Meadville, PA 16335
(814) 333-5000
www.mmchs.org

O.A.M.
Orthopedic Associates of Meadville
11277 Vernon Place, Suite 200
Meadville, PA 16335
Phone: (814) 724-1252
Fax: (814) 337-6043

OAM HIPAA Form

Form #90439
Rev 01/22

Name: _____
Medical Record#: _____
Date: _____

Patient Name _____
Date of Birth _____

NOTICE ACKNOWLEDGMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

NOTICE OF PRIVACY PRACTICES brochures are available at the registration department. I understand that Orthopedic Associates of Meadville, P.C. has the right to change its privacy practices from time to time and I may contact Orthopedic Associates of Meadville, P.C. to obtain a current copy of the brochure.

I understand that I may request in writing that you restrict how my private information is used. I also understand that by law you may not be able to agree to the requested restrictions.

Name: _____ **Signature:** _____ Date: _____

MEDICAL RELEASE (including minors)

I hereby authorize Orthopedic Associates of Meadville, P.C. to furnish information and/or discuss information contained in my medical record, including appointment information, treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis with the following person or persons: (including nurse case managers, if applicable). Any request to restrict this information must be submitted in writing, I also understand that by law OAM may not be able to agree to the requested restrictions.

YOU MUST LIST THE NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN RELEASE INFORMATION TO, EITHER WRITTEN OR VERBALLY, REGARDING YOUR CARE

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Further, I hereby authorize and give my consent to Orthopedic Associates of Meadville, P,C. to leave messages on my answering machine/voicemail system for the following:

_____ Appointment reminders (including return telephone calls)
_____ Prescription Refills
_____ Test Results
_____ **Do not leave message**

_____ Permission to fax work status reports to employer
_____ Permission to fax gym/school excuses to school

Signature _____ Date _____

As part of their education, residents, students, and interns may be present for or participate in your care. Our physicians are responsible to oversee, direct and monitor each student. While a resident, intern or student may perform care without the attending physician present, rest assured that our physicians make all final decisions regarding your care and treatment.

AT ANY TIME, YOU HAVE THE RIGHT TO REQUEST THAT A RESIDENT, INTERN, OR STUDENT IS NOT PRESENT FOR YOUR CARE AND DOES NOT PERFORM YOUR CARE.

Your signature acknowledges you have received and read this information regarding your rights.

Signature _____ Date _____