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

HIP HISTORY

Form 90455
Rev 01/23

Name: _____
Chart: _____
Date: _____

Name: _____ DOB: _____

1. Reason for visit (include left or right) _____
2. Date of onset (beginning) of complaint/injury _____
3. What activity were you engaged in and where did it happen? _____
4. Describe complaint (ache, pain, throb, lump, etc.) _____
5. Is there associated pain elsewhere? If so, describe _____
6. What is the effect of activity? Does it make the pain better or worse? _____
7. Do you use _____ cane _____ walker _____ crutches? If yes, how often? _____
8. Do you use _____ furniture _____ shopping carts for support?
9. What is the effect of weather changes? _____
10. Any numbness or tingling in your arm or leg? _____
11. Any fever, chills, appetite loss, unexpected weight loss? _____
12. Does aspirin, Advil/Motrin(ibuprofen), Aleve(naproxen),Tylenol(acetaminophen), etc. help? _____
13. Does the pain awaken you from sleep? _____
14. Are there other symptoms? If so, describe _____
15. Describe any similar episodes in the past _____
16. Current treatment _____
17. Other physicians consulted for this problem? _____
18. Status now compared to onset? Better/worse/same _____
19. If off work because of this problem, state date last worked _____

Have one or more of the below conservative treatments been tried?

- ☐ Anti-inflammatory medication:
  Name of medication _____ Duration _____
- ☐ Pain Medicine:
  Name of medication _____ Duration _____
- ☐ Home exercise: _____ Duration _____
- ☐ Physical therapy: _____ Duration _____
- ☐ Use of a cane or walker: _____ Duration _____
- ☐ Weight loss: _____ Duration _____
- ☐ Cortisone shot(s): _____ Duration _____

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New Patient Packet

Form #90428
Rev 03/22

Name: _____
Medical Record#: _____
Date: _____

INITIAL PAST MEDICAL HISTORY

Name _____ Date _____
Date of Birth _____ Date of injury _____

1. Do you have or have you ever had any of the following? If so, please check.

HEART AND VASCULAR	LUNGS	OTHER SYSTEMS	
___ Heart Attack	___ Bronchitis	___ Diabetes - Insulin/Non	___ Arthritis/rheumatism
___ Angina or chest pain	___ Emphysema	___ Thyroid problems	___ Glaucoma
___ High blood pressure	___ Asthma	___ Kidney/bladder problems	___ Bleeding problems/anemia
___ Palpitation/heart skipping	___ Tuberculosis	___ Stomach or duodenal ulcer	___ Psychiatric problems
___ Heart murmur	___ Sinusitis	___ Heartburn or burping	___ Back problems
___ Stroke	___ Hay-fever	___ Convulsions - epilepsy	___ Alcoholism
___ Edema - ankle swelling	___ Respiratory infections	___ Dizzy or fainting spells	___ Drug Addiction
___ Varicose veins	___ Shortness of breath	___ Hepatitis/jaundice/liver	___ Cancer - type _____
___ Phlebitis or blood clots	___ Black lung	___ Pregnant Y / N	___ Bone disorders
___ Other heart-circulation problems	___ Other lung problems	___ HIV/AIDS	___ Fibromyalgia
___ Sleep apnea	_____	___ Depression / Anxiety	___ Other _____

2. Please list prior surgeries and dates _____

3. Are you taking any medications on a daily basis? Please list below or attach a separate listing.
Drug Name Strength Dosage

4. Do you have any allergies to medications? If so, please list medication and reaction

5. List any unusual childhood illnesses (scarlet or rheumatic fever, etc.)

6. Do any medical problems run in your family? _____ DVT/Blood Clots _____ Other
_____ Hypertension _____ Diabetes _____ Heart Disease _____ Rheumatic arthritis. _____ Cancer

7. Do you smoke cigarettes, cigars or a pipe?
If so, how many per day? _____, for how many years? _____

8. Do you use recreational drugs? Yes / No _____

9. Do you drink alcohol? Yes / No If yes, how much per week _____

10. Tattoo within the past 6 months? _____

11. Do you live in a _____ one story home, _____ two story home or other? _____

12. Who lives at home with you? _____

13. Do you typically use a walker/cane/wheelchair? _____

14. What is your occupation? _____
Are you currently disabled from work? Yes / No Date you last worked? _____
Any restrictions? Lifting _____ Time _____ Other(please explain) _____

15. Are you able to operate a vehicle? _____

16. Who is your primary care physician? _____

(for office use) Height _____ Weight _____ B/P _____ Age _____ BMI _____

The above information is true and complete to the best of my knowledge.

Patient Signature _____ Date _____

Physician/PA Signature _____ Date _____

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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 _____