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

KNEE HISTORY

Form 90454
Rev 01/23

Name: _____
Chart: _____
Date: _____

Name _____ Date of Birth _____

Is this examination for your _____ right knee _____ left knee or _____ both knees?

Is this problem due to any of the following?

_____ Auto accident
_____ Falling
_____ Motorcycle accident
_____ Snowmobile accident/ATV accident
_____ Sports injury
_____ Work related

_____ Other, please state _____

Where did injury occur? _____

BRIEF HISTORY OF ONSET AND DURATION OF KNEE PROBLEM: _____

If you are having pain, please check all that apply:

_____ Daily pain (limits normal daily activities)
_____ Night pain
_____ Pain limiting sleep
_____ Lower extremity numbness or tingling

PLEASE CIRCLE EACH ANSWER.

Do you have knee pain in the morning? YES NO
Do you have knee stiffness in the morning? YES NO
Do you have swelling in your knee? YES NO
Have you had any swelling in your knee in the past? YES NO
If yes, please state when this occurred _____
Have you had any swelling in other joints? YES NO
Do you have pain in your (please circle) hip low back groin region?
Do you have pain in your knee when _____ walking _____ running _____ sitting _____ standing for prolonged periods of time?
Do you use _____ cane _____ walker _____ crutches? If yes, how often? _____
Do you use _____ furniture _____ shopping carts for support?
Do you have pain on climbing stairs? YES NO
Do you have a grinding sensation in your knee? YES NO
Do you have a clicking sensation in your knee? YES NO
Do you have a feeling of giving way in your knee? YES NO
Does rainy weather bother your knee? YES NO
Does activity make it (please circle) better or worse?
Do over the counter pain medications relieve the pain or ache in your knee? YES NO
If yes, which _____
Can you fully straighten your knee? YES NO
Have you had a previous injury or problem with your knee? YES NO
If yes, please state how this occurred, date and treatment _____

Are you on any medications at the present time for this problem? YES NO
If you, please state _____
Have you attempted any weight loss as treatment for this problem? YES NO
Have you tried a brace or other knee support? YES NO
Has physical therapy or therapeutic exercise been attempted? YES NO
If you have seen another physician for this problem, please name _____

If you have been off work because of this problem or injury, please give the date last worked _____
Other history or information, please use reverse side if more room or further communication is needed: _____

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A M B O A M N E W P T

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
___ Heart Attack
___ Angina or chest pain
___ High blood pressure
___ Palpitation/heart skipping
___ Heart murmur
___ Stroke
___ Edema - ankle swelling
___ Varicose veins
___ Phlebitis or blood clots
___ Other heart-circulation problems
___ Sleep apnea

LUNGS
___ Bronchitis
___ Emphysema
___ Asthma
___ Tuberculosis
___ Sinusitis
___ Hay-fever
___ Respiratory infections
___ Shortness of breath
___ Black lung
___ Other lung problems
_____

OTHER SYSTEMS
___ Diabetes - Insulin/Non
___ Thyroid problems
___ Kidney/bladder problems
___ Stomach or duodenal ulcer
___ Heartburn or burping
___ Convulsions - epilepsy
___ Dizzy or fainting spells
___ Hepatitis/jaundice/liver
___ Pregnant Y / N
___ HIV/AIDS
___ Depression / Anxiety
___ Arthritis/rheumatism
___ Glaucoma
___ Bleeding problems/anemia
___ Psychiatric problems
___ Back problems
___ Alcoholism
___ Drug Addiction
___ Cancer - type _____
___ Bone disorders
___ Fibromyalgia
___ 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

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

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 _____