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

SHOULDER HISTORY

Form 90453
Rev 01/23

Name: _____
Chart: _____
Date: _____

NAME _____ **DATE** _____

Please answer the following questions that pertain to your injury or problem with your shoulder by checking, circling or writing the answer. Thank you

Is this exam for your right shoulder _____ left shoulder _____ both shoulders _____ ?

Please give the date you began having trouble with your shoulder or the date you injured your shoulder _____

Where did your injury occur? _____

Are you right or left handed? _____

Is this injury due to the any of the following?

_____ Auto accident
_____ Falling
_____ Motorcycle
_____ Football
_____ Wrestling
_____ None of the above please state here _____

_____ Snowmobile accident
_____ Baseball accident
_____ Basketball accident
_____ Skiing accident

BRIEF HISTORY: _____

_____

If you are having pain, please check one of the following:

_____ Severe pain (prevents normal daily activity)
_____ Throbbing pain
_____ Moderate pain
_____ Aching pain

PLEASE CIRCLE EACH ANSWER. THANK YOU.

Do you have pain at night?	YES	NO
Do you have neck pain?	YES	NO
Is the neck pain necessarily related to your shoulder pain?	YES	NO
Does your pain go down into your right arm?	YES	NO
Does your pain go down into your left arm?	YES	NO
Have you had any swelling in your fingers?	YES	NO
Have you had any other joint pain or swelling?	YES	NO
Does it hurt you to move your shoulder forward?	YES	NO
Does it hurt you to move your shoulder upward?	YES	NO
Do you have a grinding sensation in your shoulder?	YES	NO
Do you have a clicking sensation in your shoulder?	YES	NO
Do you have stiffness in your shoulder in the morning?	YES	NO
When you use your arm, does your shoulder hurt in the morning?	YES	NO
When you use your arm, does your shoulder get worse?	YES	NO
Is your shoulder swollen?	YES	NO
Have you had previous problems or injury to your shoulder?	YES	NO

If yes, please state when and what kind of treatment you received

_____

Have you had any treatment for your present shoulder problem? **(IE: PHYSICAL THERAPY OR HOME EXERCISE)**
YES NO If yes, please state when and what kind of treatment. **(IF INJECTIONS, HOW LONG?)** _____

_____

Are you on any medications at the present time for this problem? **(IE: MOTRIN(ibuprofen), ALEVE(naproxan), TYLENOL (acetaminophen))**
YES NO If yes, please state here _____

If you have seen another physician for this problem, please give name and address _____

_____

If you have been off work because of this problem or injury, please give the date you last worked. _____

_____

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New Patient Packet

Form #90428
Rev 03/22
Page 1 of 2

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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A M B O A M N E W P T

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 _____