Date: ______________

Patient Name: ____________________________________ **Date of Birth:** ___________

Address: ____
Street City State Zip

Cell Phone: ______________ Home Phone: _____________ Work Phone: ______________

Email: _________________________ Sex: ☐ M ☐ F Race/Ethnicity: __________________

Height: ____ Weight: _____ Occupation: _______________ Employer's Name: _________________

Emergency Contact Name: _______________ Tel: ___________ Relationship to Patient: ___________

Primary Care Physician: ________________________ Phone: ____________ Fax: _____________

Preferred Pharmacy (Name, Address, Phone): ____

____

Primary Insurance

Name: ___________________ Phone:___________ Group #: __________ ID #: ________________

Subscriber Name (If not patient): _________________ Subscriber DOB: _______ Effective Date: _________

Secondary Insurance

Name: ___________________ Phone:___________ Group #: __________ ID #: ________________

Subscriber Name (If not patient): _________________ Subscriber DOB: _______ Effective Date: _________

Chief Complaint

Side: ☐ Left ☐ Right ☐ Both **Body Part:** ☐ Shoulder ☐ Knee ☐ Hip Other: _____________

Duration of symptoms: ____________ Pain rating (0-10): ________

Briefly describe origin of current problem and current symptoms: _________________________________

____

What makes your symptoms worse: ____

Recent Trauma history to the affected area? ☐ Yes ☐ No If yes, Injury date: __________

Prior Injuries to the affected area? ☐ Yes ☐ No If yes, Prior Injury date: ___________

Description (If yes to above 2 questions): ____

Important Sports/Recreational Activities/Hobbies: ____

Additional information: ____

Treatment: ☐ None If yes to prior treatment, list details below.

☐ Activity Modification: ______________________________

☐ NSAIDS (e.g Ibuprofen, Naproxen. List dose/frequency): ______________________________

☐ Oral Medications (Tylenol, Other Meds. Dose/frequency): ______________________________

☐ Physical Therapy (Name/Location/# sessions attended): ______________________________

☐ Home Exercise Program (Exercises/frequency): ______________________________

☐ Injections (Steroid, Gel, PRP. Date/Type of Injection/Outcome): ______________________________

☐ Imaging (X Rays, MRI, CT, Nerve Conduction. Date/Imaging center name): ______________________________

☐ Prior Surgery (Date/Procedure/Surgeon/Outcome): ______________________________

☐ ER Visit (Date/Hospital name/Treatment): ______________________________

☐ Urgent Care Visit (Date/Facility name/Treatment): ______________________________

☐ Splinting/Bracing (Date/Duration of use): ______________________________

☐ Treatment by Another Physician (Date/Name/Treatment): ______________________________

☐ Assistive Devices (Cane, Scooter, Walker. Frequency):______________________________

☐ Other/Additional Information: ______________________________

Past Medical History: ☐ None

☐ Asthma
☐ Autoimmune disorder
☐ Bleeding disorder
☐ Cancer
☐ Coronary artery disease
☐ Chronic pain
☐ Diverticulosis
☐ Drug/Alcohol abuse
☐ DVT (Blood clots)/PE
☐ Emphysema/Bronchitis
☐ GERD
☐ GI ulcers
☐ Gout
☐ Hepatitis C
☐ HIV
☐ Hypercholesterolemia
☐ Hypertension
☐ Hypothyroidism
☐ IDDM
☐ Kidney disease
☐ Liver disease
☐ Narcotic use (in the past)
☐ Narcotic use (active)
☐ NIDDM
☐ Osteoarthritis
☐ Osteoporosis
☐ PVOD
☐ Renal disease
☐ Rheumatoid arthritis
☐ Smoking
☐ Steroid use
☐ Other: _______________

Past Surgical History: ☐ None Please list the date of surgery next to the procedure.

☐Cervical spine surgery
☐ Lumbar spine surgery
☐ Shoulder arthroscopy (Left)
☐ Shoulder arthroscopy (Right)
☐ THA (Left)
☐ THA (Right)
☐ Knee arthroscopy (Left)
☐ Knee arthroscopy (Right)
☐ TKA (Left)
☐ TKA (Right)
☐ Appendectomy
☐ Cholecystectomy
☐ Hysterectomy
☐ Partial colectomy
☐ Tonsillectomy
☐ Vasectomy
☐ Wisdom teeth extraction
☐ Other: ___________________

Family History (Family members with a history of blood clots (DVT), pulmonary embolism (PE), cancer, heart attack, stroke, autoimmune disease, or other serious medical condition): ☐ None

____

Social History:

Smoke/Use tobacco: ☐ Yes ☐ No If yes, packs/day: _____ Number of years smoking: ______

Drink alcohol: ☐ Yes ☐ No If yes, how much/how often: ____

Street drugs: ☐ Yes ☐ No If yes, which drugs, how much, and how often: ___________________________

Allergies: ☐ None ☐ Penicillin ☐ Latex ☐ Other: ____

Medications (Name, dose, frequency): ☐ None ____

____

____

Review of Systems: ☐ Negative for all items listed below

Constitutional: ☐ Weight loss ☐ Loss of appetite ☐ Fatigue

Eyes: ☐ Blurred vision ☐ Double Vision

Cardiovascular: ☐ Chest pain ☐ Irregular heartbeat

Respiratory: ☐ Chronic cough ☐ Shortness of breath

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Blood in stool ☐ Abdominal pain ☐ Diarrhea

Genitourinary: ☐ Blood in urine ☐ Difficulty urinating ☐ Recurrent bladder infections ☐ Kidney problems

Skin: ☐ Rashes ☐ Chronic skin ulcers/wounds

Neurological: ☐ Headaches ☐ Dizziness ☐ Seizures

Psychiatric: ☐ Persistent difficulty sleeping ☐ Feelings of hopelessness ☐ Excessive sadness

Endocrine: ☐ Unintentional weight loss ☐ Rapid weight gain

Hematologic/Lymphatic: ☐ Easy bleeding ☐ Excessive bruising ☐ Chronic arm or leg swelling

Worker's Compensation (If applicable): Company Name: ______________________________________

Adjuster: ______________________ Adjuster Phone: _______________ Adjuster email: _________________

Claim #: ____________________ Date of Injury: ____________

Dr. John Austin has the ability to send your statements through McGavran Billing (our billing partner) electronically at mcgavranbilling@gmail.com. If you would like to receive your statements via email please check the box below and provide your email address.

☐ Yes, I would like to receive statements at the following email address: _____________________

☐ No, I would like to receive a paper statement. Send paper statement to my home address unless I indicate a different address here: ____

Northwest Orthopaedic Surgery
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San Diego, CA 92126
858.703.6964 O
858.800.2518 F

Consent for Evaluation and Treatment

I consent to the evaluation and treatment of the condition for which I (or my child/dependent) have come to Northwest Orthopaedic Surgery. I authorize the physicians (and other health care providers and staff associated with Northwest Orthopaedic Surgery) to provide such evaluation and treatment. I understand that medical staff and medical providers in training may be involved in my care and treatment, and I consent to their involvement. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, diagnosis, treatment, or test performed at or by Northwest Orthopaedic Surgery. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Northwest Orthopaedic Surgery.

☐ **I Agree to the above Consent for Evaluation and Treatment**

Consent for Procedures

Certain orthopaedic conditions may require additional testing and/or procedures as part of the treatment plan. The tests and/or procedures are separate from the physician's office visit and thus have a separate charge. These tests and/or procedures include, but are not limited to:

- Steroid Injection
- Hyaluronic Acid Injection
- Biologic Injection
- Local Anesthetic Injection
- Casting/Splinting
- Fracture Treatment (including Manipulation)
- Durable Medical Equipment
- Minor Surgical Procedures and/or biopsies

☐ **I Agree to the above Consent for Procedures**

I have had the opportunity to discuss this consent, and my questions have been answered to my complete satisfaction.

Signature of Responsible Party: ________________________________ Date: ____________