Spine, Orthopaedic & Pain Surgical Partners

PATIENT MEDICAL HISTORY FORM

FORMA DE HISTORIA MEDICA DEL PACIENTE DATE/*FECHA*

NAME _____ AGE: _____ BIRTHDATE: _____
NOMBRE *EDAD* *FECHA DE NACIMIENTO*
OCCUPATION: _____ SEX: _____ MARITAL STATUS S M W D
OCCUPACION *SEXO* *ESTADO MARITAL*

REASON FOR OFFICE VISIT

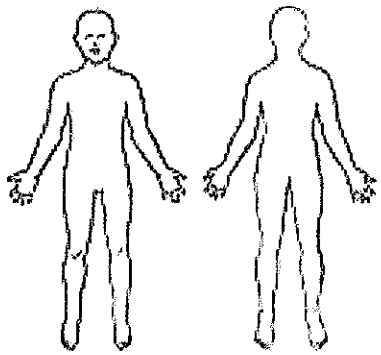
Injury: _____ Date of Injury: _____ Where did injury occur? ☐ on the job ☐ automobile
Accidente *Fecha del Accidente* *Lugar donde ocurrio ? en el trabajo automobile*
☐ Other Describe if other: _____
Otro *Fecha del Accidente*

Have you suffered a previous on the job injury? ☐ Yes ☐ No A previous automobile injury? ☐ Yes ☐ No
Ha sufrido accidents previos en el trabajo Si No Un Accidente de automobile previo? Si No

Have you suffered a previous injury of any kind to the same area of the body? ☐ Yes ☐ No
Ha sufrido cualquier otra clase de accidente en la misma parte del cuerpo? Si No

Present Symptoms: ☐ Pain ☐ Numbness ☐ Unable to bend/fles/lift/move without pain ☐ Headaches ☐Nausea ·
Sintomas presentes: *Dolor* *Adormecido* *No se puede estirar o doblar sin dolor* *Dolor de cabeza* *Vomitos*
☐ Dizziness ☐ Other: _____
Mareos Otro

Please mark with an "X" the areas which you feel pain or discomfort
Por favor marquee con una "X" en areas en cuales siente dolor o malestar



FRONT *FRENTE* BACK *ATRAS*

PRESENT MEDICAL TREATMENT *TRATAMIENTO MEDICO PRESENTE*

Are you presently under a doctor's care? ☐ Yes ☐ No If yes, name of Doctor
Esta usted ahora bajo el cuidado de un medico? ☐ Si ☐ No Si su respuesta es afirmativa nombre de medico

Date first seen *Fecha de la primera visita* _____ Date last seen *Fecha de la ultima visita* _____
Are you presently receiving medical treatment or physical therapy? ☐ Yes ☐ No
Esta usted recibiendo tratamiento medico o terapia fisica?

If yes, pleas indicate date of last treatment: _____
Si su repuesta es afirmativa, indique la fecha de el ultimo tratamiento

Please describe nature of treatment being received. *Por* favor describa la naturaleza de el tratamiento recibido _____
_____

PREVIOUS SURGERY – HOSPITALIZATION *PREVIAS CIRUGIAS – HOSPITALIZACION*

Please list all previous surgeries or serious illnesses requiring hospitalization, starting with the latest occurrence.
Por favor anote totas las cirugias previas o enfermedades serias que haya requerido hospitalizacion

DATE FECHA	INJURY/ILLNESS ACCIDENTE/ENFERMEDAD	HOSPITAL NAME NOMBRE DEL HOSPITAL

Please list all medications that you are presently taking. *Por favor anote todas las medicaciones que este tomando ahora:* _____
_____

Please list all drug allergies. *Por favor anote todas sus alergias medicina:* _____
_____

FAMILY HISTORY *HISTORIA FAMILIA*

1. Your Father: ☐ Alive ☐ Dead _____
   Padre Vivo Muerto Cause of Death / *Causa de Muerte*
2. Your Mother: ☐ Alive ☐ Dead _____
   Madre Vivo Muerto Cause of Death / *Causa de Muerte*
3. Your Brothers and Sisters: No. Living No. Dead
   Sus Hermanos y Hermanas No. Vivos No. Muertos

Cause of Death(s) *Causa de esas muertes* _____
Total No. _____

DO YOU HAVE A FAMILY HISTORY OF:
TIENE USTE HISTORIA FAMILIAR DE:

	No	Yes/Si
1. Heart disease *Enfermedades del Corazon*	____	____
2. High Blood Press. *Presion alta*	____	____
3. Diabetes *Diabetis*	____	____
4. Stroke *Derrame cerebral*	____	____
5. Cancer (LOCATION) *Cancer (LUGAR)*	____	____
6. Thyroid Disease *Entermedad de la tiroides*	____	____
Other Disease *Otras Enfermedades*		

REVIEW OF YOUR BODY SYSTEMS *REVISION DE LOS SISTEMAS DEL CUERPO*

Do you have now or have you ever had any of the following? *Tiene o ha tenido cualquiera de las siguientes?*

		No	Yes/*Si*	Please Explain/*Por favor Explique*
1.	Ulcers *Ulceras*	____	____	_____
2.	Colitis *Colitis*	____	____	_____
3.	Rectal Bleeding *Sangramiento rectal*	____	____	_____
4.	Change in Bowel Habits *Cambio en habitos al ir al bano*	____	____	_____
5.	Black Tarry Stools *Defecaciones de color negro*	____	____	_____
6.	Heart Disease *Enfermedes del Corazon*	____	____	_____
7.	High Blood Pressure *Presion alta*	____	____	_____
8.	Chest Pain *Dolor en el pecho*	____	____	_____
9.	Cough Blood *Tose sangre*	____	____	_____
10.	Shortness of Breath *Dificultidad al respirar*	____	____	_____
11.	Thyroid Disease *Enfermedades de la Tiroides*	____	____	_____
12.	Lung Disease *Enfermedades Pulmonares*	____	____	_____
13.	Cancer (Location) *Cancer (Lugar)*	____	____	_____
14.	Asthma or Emphysema *Asma o inflamacion pulmonar*	____	____	_____
15.	Hepatitis (jaundice or liver disease) *Hepatitis*	____	____	_____
16.	Gallbladder Disease *Enfermedad de la vesicula*	____	____	_____
17.	Venereal Disease *Enfermedades venereas*	____	____	_____
18.	Kidney Stone(s) *Calculos en los ninones*	____	____	_____
19.	Blood in Urine *Sangre en la orina*	____	____	_____
20.	Epilepsy *Epilepsia*	____	____	_____
21.	Swollen or Painful Joints *Articulaciones inflamados o con dolor*	____	____	_____
22.	Nervous Disorder *Desordenas nerviosos*	____	____	_____
23.	Depression *Depresion*	____	____	_____
24.	Diabetes *Diabetis*	____	____	_____
25.	Stroke *Derrame cerebral*	____	____	_____
26.	Back Disorder *Desordenes de la espalda*	____	____	_____
27.	Blood Disease or Anemia *Enfermedades de la sangre o anemia*	____	____	_____

PERSONAL HISTORY *HISTORIA PERSONAL*

YOUR CHILDREN: Living _____ List any serious diseases in children _____
SUS NINOS: No. Vivos _____ *Anote algunas enfermedades serias de sus hijos* _____

Number deceased children: _____ Cause: _____
Numero de fallecidos hijos: _____ Causa: _____

YOUR PERSONAL HABITS: Do You?
SUS HABITOS PERSONALES: Tien usted alguno?

	No	Yes/*Si*	Please Explain *Por Favor Explique*
Regularly exercise (3 or 4 times/week) *Hace ejerciocios periodicamente ¾ Veces a la semana*	_____	_____	_____
Wear auto seatbelts (90% of time) *Usa cinturon de seguridad en su auto 90% del tiempo*	_____	_____	_____
Use illegal drugs *Usa drogas ilegales*	_____	_____	_____
Use alcohol *Toma bebidas alcoholicas*	_____	_____	_____
Were you ever a heavy drinker *Ha sido usted alcoholico*	_____	_____	_____
Smoke *Fuma*	_____	_____	_____

If ever, when did you stop? _____
Si alguna vez lo hizo cuando paro?

HAVE YOU RECENTLY BEEN TROUBLED WITH ANY OF THE FOLLOWING SYMPTOMS?
HA TENIDO USTED PROBLEMAS RECIENTES CON ALGUNO DE LOS SINTOMAS QUE SIGUEN?

YES *SI*	NO		YES *SI*	NO		YES *SI*	NO	
		Headaches *Dolor de cabeza*			Cough *Tos*			Abnormal bleeding *Sangramiento anormal*
		Double Vision *Vision doble*			Bloody sputum *Sangre cuando escupe*			Painful urination *Dolar cuando orina*
		Nosebleeds Sange de nariz			Wheezing *Chilido en el pecho*			Nocturia *Orina frequentemente por la noche*
		Difficulty Swallowing *Dificulidad al tragar*			Indigestion *Indigestion*			Blood in urine *Sangre en la orina*
		Hoarseness *Ronquera*			Abdominal Pain *Dolor en el abdomen*			Pus in urine *Pus en la orina*
		Dizziness *Mareos*			Diarrhea *Diarrea*			Slow Stream *orina depacio*
		Shortness of Breath *Difficultad al respirar*			Constipation *Estrenimiento*			Painful joints *Dolor en las articulaciones*
		Chest pain or pressure *Dolor o presion en el pecho*			Recent change in bowel habits *Cambio en sus habitos al ir al bano*			Backache *Dolor de espalda*
		Vomited blood *Vomita sangre*			Paralysis *Paralisis*			Irregular heart beat *Palpitaciones irregulars*
		Swelling of Feet *Inflamecion de los pies*			Blood in Stool *Sangre cuando defeca*			Fainting spells *Sensasiones de desmayo*
		Leg pain *Dolor en las piemas*			Yellow Jaundice *Color amarilo en la piel*			Depression/Worry *deprimido/Preocupado*

Weight: Usual _____ Present _____ Greatest: _____ Ideal: _____
Peso: Usual *Presente* *Mas Pesado* *Ideal:*

WOMEN ONLY

Menstrual Periods: Age onset Periods regular or irregular
Periodos Menstruels: Feche que comenzo Periodos regulares o irregulars
Date last period Difficulty with periods
Fecha de el ultimo periodo Dificultad con sus periodos
Pregnancies: Number of children born alive Number of cesarean sections
Embarazos: Numero de ninos nacidos con vida Numero de cesareas
Number of prematures Number of stillborns Miscarriages
Numero de partos prematuros Numero de nacidos con vida Abortos
Describe any complications *Describa algunas complicaciones:*

IMMUNIZATIONS *VACUNAS*

Smallpox / Viruela _____ Tetanus / Tetano _____

Polio / Poliomyelitis _____ Other / Otros _____

PHYSICIAN/PATIENT MEDICATION CONTRACT

THE GOAL OF INTRACTABLE PAIN MANAGEMENT IS TO ENHANCE PHYSICAL, PSYCHOLOGICAL, AND SOCIAL WELL-BEING. THE RETURN OF OPTIMAL FUNCTION IS THE MAJOR EPHASIS.

1. Patient will have regularly scheduled office visits with periodic blood draws to monitor drug side effects. At office visits, careful documentation will be made of drug efficacy, opioid toxicity and drug misuse or abuse.

2. Patient and physician will agree upon a time frame in which medication adjustments (titration) are made, aiming for at least partial relief of pain. After optimum dose of a selected drug has been determined, and agreed-upon monthly quantity of drug will be prescribed. Some leeway in daily dosage may be approved by the physician.

3. Patient will use controlled substances as prescribed. Scheduled and breakthrough doses may be allowed if written by physician.

4. Prescriptions will not be filled early due to lost or stolen prescriptions, lost or stolen drugs, going out of town, etc. In certain select situations (i.e. proof of theft with police report, or airline tickets if leaving town) exceptions may be made.

5. Patient agrees to ensure the safe and secure storage of medications prescribed, to ensure that no one other than the patient will have access to the medications (i.e. children, houseguests, etc)

6. No refills will be given on weekends, holidays, or after 5:00 p.m. on weekdays. Chart review for approval is not possible at these times.

7. Patient will not get any prescription narcotics, muscle relaxants, anti-anxiety medications, or other controlled substances without Spine, Orthopaedic & Pain Surgical Partners' approval.

8. Drug hoarding, diversion, or acquisition elsewhere will result in tapering of opioid dosage and cessation of maintenance therapy.

9. Patient will not drink alcohol with any controlled substances or medications prescribed for pain control, muscle relaxation, and/or anxiety.

10. If adequate pain control is not achieved on an outpatient basis, patient may be hospitalized for pain control and adjustment of medications.

11. Patient may be referred to a chronic pain unit or inpatient hospitalization with psychiatric supervision in certain select circumstances, such as:

    a. Patient request
    b. Rapid escalation of drug dosage, or escalation without subsequent decrement
    c. Difficult pain control situations requiring unusually high doses of narcotics.
    d. Attempted overdose or suicide attempt

12. Deviation from this contract will result in tapering of opioid dosage and cessation of maintenance terapy.

I HAVE READ ALL PARTS OF THIS CONTRACT. I HAVE BEEN ALLOWED TO ASK QUESTIONS AND HAVE RECEIVED ANSWERS TO MY SATISFACTION. I AGREE TO ABIDE BY THE RULES AS OUTLINED IN THIS CONTRACT.

PATIENT _____ **DATE** _____

PHYSICIAN _____ **DATE** _____

Advanced Medical Group/Spine, Orthopaedic & Pain Surgical Partners

Consent to Treat / Assignment of Benefits And/Or Claims

Date: _____

Patient: _____

I hereby consent to receive treatment from ADVANCED MEDICAL GROUP / SPINE, ORTHOPAEDIC & PAIN SURGICAL PARTNERS for my medical condition and/or injury.

I hereby acknowledge that many providers at ADVANCED MEDICAL GROUP / SPINE, ORTHOPAEDIC & PAIN SURGICAL PARTNERS are independent contractors and not employees of ADVANCED MEDICAL GROUP / SPINE, ORTHOPAEDIC & PAIN SURGICAL PARTNERS.

I understand that various staff physicians and other healthcare professionals, including physician assistants, certified staff or other persons under the supervision of the medical director, may treat me.

I understand that my treatment plan will be explained to me and that I have the right to refuse and/or discontinue treatment at any time.

I hereby authorize ADVANCED MEDICAL GROUP / SPINE, ORTHOPAEDIC & PAIN SURGICAL PARTNERS to release any information acquired in the course of my examination and treatment in accordance with their HIPAA Policies and Procedures. (Texas Division of Workers Compensation Guidelines in the event I was involved in an on-the-job injury)

I hereby authorize payment directly to ADVANCED MEDICAL GROUP / SPINE, ORTHOPAEDIC & PAIN SURGICAL PARTNERS for the surgical and/or medical benefits, if any, otherwise payable to me for their services. I understand that this authorization does not release me from my personal responsibility for payment of all charges. I do understand that I am ultimately responsible for payment of all charges.

In addition, I hereby authorize payment directly to ADVANCED MEDICAL GROUP / SPINE, ORTHOPAEDIC & PAIN SURGICAL PARTNERS for medical benefits and/or personal injury protection coverage, if any, otherwise payable to me for services. I understand that this authorization does not release me from my personal responsibility for payment of all charges. I hereby assign an undivided interest that I have under any medical benefits, personal injury protection and/or any tort claim(s) that I have arising out of the accident of _____ 20_____. This assignment entitles ADVANCED MEDICAL GROUP / SPINE, ORTHOPAEDIC & PAIN SURGICAL PARTNERS an undivided interest in any settlement or judgment arising from my aforesaid claim(s).

I swear that the information that I give the doctor and staff I true and correct. I understand that the doctor will be relying upon the information and representations made by me to treat me appropriately, and therefore I must be truthful.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature Relationship to minor

Spine, Orthopaedic & Pain Surgical Partners
15119 Wallisville Rd., Suite 200
Houston, TX 77049

Medical Records Release Form

PATIENT NAME: _____ **DOB:** _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Patient Initials _____ **Date** _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

_____

The following person(s)/entity may release my protected health information to ADVANCED MEDICAL GROUP / SPINE, ORTHOPAEDIC & PAIN SURGICAL PARTNERS:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The reason or purposes for this release of information are as follows:

_____

_____

_____ _____

_____ Sign Only

Patient Signature (or parent, guardian or legal representative)

_____

Date

This Authorization Expires on: _____ 20 _____

Spine, Orthopaedic & Pain Surgical Partners, LLC

THIS FORM REQUIRED FOR EACH VISIT

PATIENT NAME: _____ DATE: _____
PHONE NUMBER: _____ ALTERNATE NUMBER: _____
ADDRESS: _____ CITY, STATE, ZIP _____

Please circle the following area(s) you are currently having any problems, signs, or symptoms in:

General wellness	Neurological	Eyes	Allergies	Joints/Bones
Skin	Reproduction/Urinary	Ears/Nose, Throat	Thyroid/Endocrine	Blood/Lymph
Stomach/Digestion	Depression	Nervousness	Lungs/Breathing	Other (Explain)
Heart/Circulation	Dizziness	Giddiness	Fatigue	
Trouble Sleeping	Memory	Chest Pain	Muscles	

Pain level on scale 1-10: _____

What type of pain do you feel?

Itching	Aching	Locking
Swelling	Limping	Weakness
Tingling	Numbness	Giving-Away
Burning	Stabbing	Throbbing
Other:		

Where is the Pain?
Please state right/left when referring to extremity

How often is the pain?
Constant Occasional Seldom

When does the pain occur?
Morning Afternoon Night

How is the pain usually brought on?

What other problems do you have that you feel are because of the pain?

Headaches	Bowel Problems
Blurring Vision	Bladder Problems
Erectile Dysfunction	
Other:	

What relieves your pain?

Rest	Elevation of the Body Part
Medications	Physical Therapy
Other:	

What makes your pain worse?

Bending	Standing	Running
Riding in Vehicles	Walking	
Changes in Weather	Stooping	
Other:		

Have you seen any other doctors since your last visit? Yes No
If Yes, Name: _____
Date: _____
Reason: _____

Have you had any tests since your last visit? Yes No
If Yes, Name: _____
Date: _____
Reason: _____

Reason for today's visit:

List any allergies you have:

Current Medications:

Since your last visit, please note any changes to marital status, job, smoking or drinking history:

ADDITIONAL COMMENTS / COMMENTARIOS: