

Name: _____

Date: _____ Name Preferred _____

New patient: _____ Returning patient _____



Patient Information

Home Address _____	Suite or Apt. # _____
City _____	State _____ Zip Code _____
Telephone Home: _____	Work _____ Cell _____
Soc Sec Number _____	Birthdate _____ Age _____ Gender M F
E-mail address _____	Employer _____
Emergency Contact Name _____	Relationship _____
Address _____	City _____ State _____ Ph# _____

Who referred you to Dr. Petty? _____
 Primary Care Physician _____

Primary Insurance Co _____	Group# _____	ID# _____
Policy Holder's Name _____	Date of Birth _____	
Secondary Insurance Co _____	Group# _____	ID# _____
Policy Holder's Name _____	Date of Birth _____	

Work Comp Patients: Employer Address _____
 Safety Director Name _____ Phone _____ Ext. _____
 WC Ins Carrier _____ Case Manager _____ Phone _____

Patients Under 18: Responsible Parent/Guardian _____ SS# _____
 Employer of Responsible Party _____ Employer Phone# _____
 Employer Address _____ City _____ State _____ Zip _____
 Name of School if Patient is a Student _____

Athletes
 I am, or am the parent/guardian of, a member of the _____ team at _____
 school/university, and do hereby authorize Damon H. Petty, MD and Petty Orthopaedics, PC to release medical information
 pertaining to the treatment of my _____ to my team coaches and/or trainers.
 Signature _____ Date _____

Irrevocable Assignment of Insurance Benefits (All patients)
 I, the undersigned, irrevocably assign Damon H. Petty, MD and Petty Orthopaedics, PC, all insurance payments made payable
 to me or on my behalf, including, but not limited to, surgical, medical, liability, or other for all charges for services rendered to
 me. I irrevocably instruct my attorney(s), if any, to honor this Assignment. I am responsible for all charges from Damon H.
 Petty, MD and Petty Orthopaedics, PC, whether paid or unpaid by insurance. I hereby authorize Damon H. Petty, MD and Petty
 Orthopaedics, PC to release all necessary information to secure payment by insurance(s).
 Signature _____ Date _____

Name _____
 Prefer to be called _____
 Date _____ Age _____
 Height _____ Weight _____



Patient History

Complaint:

- Left
- Right

- Shoulder
- Knee
- Hip
- Elbow
- Ankle
- Hand
- Foot
- Neck
- Back

Please describe in this space the problem for which you are seeing the doctor. Please include the following: WHEN the problem started, HOW the problem started, the LOCATION and TYPE of PAIN, what makes your symptoms WORSE, what makes them BETTER, if you have seen **ANOTHER DOCTOR** and/or had surgery for this problem, or an **MRI**, and any other important details.

Is there a lawsuit regarding this problem? Y N Is this a WORK COMP injury or illness? Y N

Please circle Yes for Yourself in the **first** column and Yes or No for any BLOOD RELATIVE in the **second**.

Do you have now or have you had...

	YOU	FAMILY		EXPLAIN YES ANSWERS
High Blood Pressure -----	Yes	Yes	No	_____
Diabetes -----	Yes	Yes	No	_____
Heart Attack -----	Yes	Yes	No	_____
Coronary Artery Disease -----	Yes	Yes	No	_____
Congestive Heart Failure -----	Yes	Yes	No	_____
Stroke -----	Yes	Yes	No	_____
Blood clot (DVT) -----	Yes	Yes	No	_____
Asthma -----	Yes	Yes	No	_____
Emphysema -----	Yes	Yes	No	_____
Chronic Bronchitis -----	Yes	Yes	No	_____
Hepatitis B or C -----	Yes	Yes	No	_____
AIDS -----	Yes	Yes	No	_____
Ulcers -----	Yes	Yes	No	_____
Kidney Stones -----	Yes	Yes	No	_____
Gout -----	Yes	Yes	No	_____
Rheumatoid Arthritis -----	Yes	Yes	No	_____
Fibromyalgia -----	Yes	Yes	No	_____
Convulsions or Seizures -----	Yes	Yes	No	_____
Recurrent Bladder Infections -----	Yes	Yes	No	_____
Thyroid Problems (explain) -----	Yes	Yes	No	_____
Liver Problems (explain) -----	Yes	Yes	No	_____
Intestinal Problems (explain) -----	Yes	Yes	No	_____
Kidney Problems (explain) -----	Yes	Yes	No	_____
Bone Problems (explain) -----	Yes	Yes	No	_____
Endocrine Problems (explain) ---	Yes	Yes	No	_____
Immune System Problems -----	Yes	Yes	No	_____
ANY OTHER problems (explain) -	Yes	Yes	No	_____

(over)

Please list all your previous surgeries and the approximate dates you had them in the box below.

<input type="checkbox"/> None

List all <u>Allergies</u> to Medication here:	
List all <u>Current Medications</u> here:	

Occupation: _____	Marital Status: M S W D
# Children: _____	Ages: _____
Do you have any Recreational Activities? Y N	If so, what are they? _____
Do you smoke cigarettes, pipes or cigars? Y N	If so, how much? _____
Do you use chewing tobacco or snuff? Y N	If so, how much? _____
Do you drink alcohol? Y N	If so, how much? _____

ATHLETES	Which Sport (s) _____	School / Team _____
	Coach's Name _____	Coach's Phone _____
	Trainer's Name _____	Trainer's Phone _____
	Agent's Name _____	Agent's Phone _____

Please check the appropriate boxes below for any symptoms you are CURRENTLY having or had recently.

GENERAL <input type="checkbox"/> Unintentional Weight loss > 20 lbs <input type="checkbox"/> Fever / Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Masses / Lumps <input type="checkbox"/> Unusual bleeding HEAD/NECK <input type="checkbox"/> Headaches <input type="checkbox"/> Double vision <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Persistent sore gums <input type="checkbox"/> Hearing loss-severe <input type="checkbox"/> Blindness <input type="checkbox"/> Dry eyes SKIN <input type="checkbox"/> Rashes <input type="checkbox"/> Open wounds <input type="checkbox"/> Ulcers on feet	LUNGS / PULMONARY <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing STOMACH / INTESTINAL <input type="checkbox"/> Heartburn <input type="checkbox"/> Black, tarry stools <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Clay colored stools <input type="checkbox"/> Jaundice <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Unusual appetite loss HEART / CARDIAC <input type="checkbox"/> Chest pain <input type="checkbox"/> Short of breath <input type="checkbox"/> Palpitations <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Sleep sitting up to breathe easier	NEUROLOGICAL <input type="checkbox"/> Depression <input type="checkbox"/> Memory loss <input type="checkbox"/> Personality changes <input type="checkbox"/> Speech changes <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Disinterest in hobbies <input type="checkbox"/> Anxiety <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Substance addiction <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremor / Shaking <input type="checkbox"/> Numbness in hands <input type="checkbox"/> Numbness in feet GU / GYN <input type="checkbox"/> Uterine bleeding after menopause <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Blood in urine <input type="checkbox"/> Painful urination <input type="checkbox"/> Flank pain and fever	BREAST <input type="checkbox"/> New lumps / masses <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Pain MUSCULOSKELETAL <input type="checkbox"/> Knee pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Hand pain <input type="checkbox"/> Wrist pain <input type="checkbox"/> Ankle Pain <input type="checkbox"/> Foot pain <input type="checkbox"/> Knee instability <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Start-up stiffness <input type="checkbox"/> Joint Swelling (specify) _____ <input type="checkbox"/> Other: _____ _____
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