HEDLEY ORTHOPAEDIC INSTITUTE

Date:_______________________

Patient Name:	HOI Account #:
Birth Date: Age:	Sex: ☐ Male ☐ Female
Primary Care Physician:	☐ Right Handed ☐ Left Handed
Referred By:	Height: Weight:

CHIEF COMPLAINT

Why are you here today?
Which side is involved? ☐ Right ☐ Left ☐ Both
How did the INJURY or PROBLEM Happen? ☐ Accident ☐ Auto Accident ☐ Work Accident ☐ Other
When did the INJURY or PROBLEM Begin?
What makes it better?
What makes it worse?

SURGERIES / HOSPITALIZATIONS

	Type of Surgery	Year	Complications?
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Have you ever had general anesthesia?	☐ Yes ☐ No
Have any problems with anesthesia?	☐ Yes ☐ No

ALLERGIES

Are you allergic to any of the following? (Check all that apply)
☐Latex ☐Aspirin ☐Codeine ☐Sulfa ☐Penicillin ☐Keflex ☐Betadine ☐Tape
List any other Medication Allergies:
Serious side effects?
For Women: Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week#:

SOCIAL HISTORY

Occupation:
Work status: ☐ Full time ☐ Part time ☐ Work at home ☐ Retired ☐ Disabled ☐ Student
Marital Status ☐ Married ☐ Separated ☐ Single ☐ Live with Spouse or Other ☐ Live Alone
Children: ☐ No ☐ Yes How Many? / Exercise? ☐ Daily ☐ Weekly ☐ Rarely ☐ Never
What type of exercise?

Are you on a special diet?	☐ No ☐ Yes	Describe:
History of substance abuse?	☐ No ☐ Yes	Describe:
Smoke currently?	☐ No ☐ Yes	Packs per day for years.

Quit smoking? ☐ This year ☐ > 1 year ☐ > 5 years ☐ > 10 years
Previously smoked Packs per day for years.
Drink alcohol? ☐ Yes ☐ No ☐ Daily ☐ 1-2 drinks per week ☐ More than 2 drinks per week

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FAMILY HISTORY

Mother	☐Alive ☐Deceased | cause of death:	Current illness:
Father	☐Alive ☐Deceased | cause of death:	Current illness:
Brother	☐Alive ☐Deceased | cause of death:	Current illness:
Sister	☐Alive ☐Deceased | cause of death:	Current illness:

List any other family chronic illness:

MEDICATIONS INCLUDING ALL VITAMINS, MINERALS & HERBS

Medication	Dose/Frequency	How Long Taking?	Side Effects

PHARMACY INFORMATION

What is the name of your pharmacy?	Address:
Phone:	Fax:

REVIEW OF SYSTEMS

Check or circle all of the following diseases or medical problems that you have had at any time?

Constitutional: ☐ Unexplained Weight Loss / Gain ☐ Fever Chills / Fatigue	Eyes: ☐ Corrective Lenses ☐ Blurred / Double Vision ☐ Eye pain
ENT: ☐ Headache ☐ Difficulty Swallowing ☐ Nose Bleeds / Ringing in Ears / Earaches ☐ Reaction to foods or environment	Cardiovascular: ☐ Heart Attack /Heart Bypass Surgery ☐ Chest pain / Palpitations / Fainting ☐ Heart Murmur / Congenital Defect ☐ High / Low Blood Pressure ☐ Pacemaker
Respiratory: ☐ Asthma / Shortness of Breath ☐ Wheezing / Cough /Snoring ☐ Sleep Apnea / Use C-pap Machine	Gastrointestinal: ☐ Heartburn ☐ Nausea / Vomiting Endocrine: ☐ Excessive Thirst / Urination ☐ Heat / Cold Intolerance ☐ Diabetes
Genitourinary: ☐ Bladder Problems / Kidney Problems ☐ Frequent / Urgent / Difficult / Painful / Blood in Urine ☐ Bowel Problems ☐ Constipation / Diarrhea / Bloody / Tarry Stools ☐ Flank Pain	Musculoskeletal: ☐ Rheumatoid Arthritis / Joint Pain / Swelling ☐ Bone Infections ☐ Artificial Bone or Joints ☐ Instability / Stiffness / Redness ☐ Muscle pain / Back Pain / Sciatica
Skin: ☐ Poor Healing / Rash / Itching / Redness	Neurologic: ☐ Epilepsy / Seizures ☐ Numbness / Tingling ☐ Unsteady Gait / Dizziness / Tremors ☐ Polio
Hematologic: ☐ Hemophilia / Abnormal Bleeding or Bruising ☐ Anemia / Transfusions / Blood Clots / Pulmonary	Psychiatric: ☐ Nervousness / Anxiety / Depression / Hallucinations ☐ Drug / Alcohol Problems
☐ Hepatitis	☐ HIV / AIDS

☐ Other Medical Problems:

Signature:	Date:
Physician Signature:	Date:

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10238 E. Hampton Ave., Suite 301A, Mesa, AZ 85209 Phone: 480 354-5900 Fax: 480 357-2415

Patient Acknowledgement:
Narcotic Medication and Refill Policy

The care of orthopedic musculoskeletal injuries or surgical intervention can obviously be painful. I understand that this pain and/or discomfort may require the use of narcotic pain medication to help ease any pain and make me more comfortable. This medication may not completely relieve my pain and/or discomfort but should make it more tolerable.

Unfortunately, due to potential complications from prolonged use of narcotics, the risk of developing medication addiction and the high incidence of narcotic abuse and street sales, I understand that the physicians of this Practice will only **issue prescriptions or prescription refills for narcotic pain medications for the maximum of six weeks following my surgery or treatment of my injury.**

I further understand that refills for any narcotic medication must be approved by my physician, and can only be refilled during regular office hours. I am aware that **there will be no narcotic medication refills authorized for me after regular office hours.**

We are sorry for any potential inconvenience that may result from this policy.

Phillip W. Bennion, M.D.
Jimmy Chow, M.D.
Brandon Gough, M.D.
Ralph T. Heap, M.D.
Brian R. McWhorter, D.O.
Michael J. Sumko, D.O.
Tim Bert, M.D.
H. Royer Collins, M.D.
Jon J. Hanlon, M. D.
Anthony K. Hedley, M.D., FRCS
Mauricio A. Valdes, M.D.
Andrew Wellman, M.D.

Acknowledged: ______________________________ ______________
Patient Signature Date