PEDIATRIC HISTORY FORM

Advanced Sportsmedicine Center

PATIENT FULL NAME:

_____

CHIEF CONCERN:

_____

CURRENT HISTORY:

3. CONSTITUTIONAL:	Yes	No
Fever	☐	☐
Weight loss	☐	☐
Ill feeling	☐	☐
4. EYES:		
Excessive Tearing	☐	☐
Blurred Vision	☐	☐
Dryness	☐	☐
5. CARDIOVASCULAR:		
Heart trouble	☐	☐
Murmurs	☐	☐
Irregular Heart Beats	☐	☐
6. ENT:		
Feeling of Dizziness	☐	☐
Ringing in Ears	☐	☐
Recent Hearing Loss	☐	☐
7. RESPIRATORY:		
Wheezing	☐	☐
Shortness of Breath	☐	☐
Cough	☐	☐
8. GI:		
Rectal Bleeding	☐	☐
Abdominal Pain	☐	☐
Black-Tar Like Stools	☐	☐
9. URINARY:		
Pain with Urination	☐	☐
Involuntary Urination	☐	☐
Urgency or frequency	☐	☐
10.MUSCULOSKELETAL		
Motion Loss	☐	☐
Swelling in Joints	☐	☐
Morning Stiffness	☐	☐
11. INTEGUMENTARY:		
Skin Rash	☐	☐
Skin Lumps	☐	☐
Abrasions	☐	☐
12. NEUROLOGICAL:		
Seizures	☐	☐
Tremors	☐	☐
Blackouts	☐	☐
13. PSYCHIATRIC:		
Inability to cooperate	☐	☐
Difficulty learning	☐	☐
Nervousness	☐	☐
14. ENDOCRINE:		
Excessive thirst	☐	☐
Excessive urination	☐	☐
Heat intolerance	☐	☐
15. HEMATOLOGIC:		
Bleed Easily	☐	☐
Past transfusions	☐	☐
Bruise Easily	☐	☐
16. IMMUNOLOGIC:		
Skin Reactions	☐	☐
Eczema	☐	☐
Severe Allergic Reactions	☐	☐

PAST HISTORY:

17A. ILLNESSES:	Yes	No
Arthritis(type)_____	☐	☐
Asthma or Bronchitis	☐	☐
Cancer (type)_____	☐	☐
Chicken pox	☐	☐
Diabetes	☐	☐
German measles	☐	☐
Measles	☐	☐
Mumps	☐	☐
Neurological Disease	☐	☐
Polio	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Whooping cough	☐	☐
17B: IMMUNIZATIONS		
Diphtheria	☐	☐
German measles	☐	☐
Measles	☐	☐
Mumps	☐	☐
Whooping Cough	☐	☐
Polio	☐	☐
Tetanus	☐	☐
Tuberculosis	☐	☐

Primary Care Physician:

Dr._____

Referral source:

_____

Preferred Pharmacy:

_____

_____

18. MEDICATIONS CURRENTLY TAKING:

NONE ☐

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

19. ALLERGIES TO MEDICATION:

NONE ☐

MEDICATION REACTION

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

20. PAST SURGERIES:	Yes	No
Appendix	☐	☐
Arthroscopy _____	☐	☐
Cancer (type)_____	☐	☐
Ear PE tubes	☐	☐
Herniorrhaphy	☐	☐
Spine	☐	☐
Tonsils	☐	☐
Wisdom teeth	☐	☐

21. OTHER HOSPITALIZATIONS:

_____

_____

_____

_____

_____

_____

22. FRACTURES:

_____

_____

_____

_____

_____

23. SOCIAL HISTORY:

Lives with mother	☐	☐
Lives with father	☐	☐

Number of living siblings ___

24. FAMILY HISTORY:

AIDS	☐	☐
Bleeding Disorders	☐	☐
Cancer	☐	☐
Heart Disease	☐	☐
Mental Illness	☐	☐
Alcoholism	☐	☐

Height:_____

Weight:_____

The above history was personally reviewed with the patient, and I agree with above.

_____

John T. Moor, MD

Updated 8/15/17

ADULT HISTORY FORM

Advanced Sportsmedicine Center

PATIENT FULL NAME:

_____

CHIEF CONCERN:

_____

REVIEW OF SYMPTOMS:

2. CONSTITUTIONAL:	Yes	No
Fever	☐	☐
Weight loss	☐	☐
Ill feeling	☐	☐
3. EYES:		
Excessive Tearing	☐	☐
Blurred Vision	☐	☐
Dryness	☐	☐
4. CARDIOVASCULAR:		
Ankle Swelling	☐	☐
Chest Pain	☐	☐
Irregular Heart Beats	☐	☐
Cardiac Stent Placement	☐	☐
5. ENT:		
Dizziness	☐	☐
Ringing in Ears	☐	☐
Recent Hearing Loss	☐	☐
6. RESPIRATORY:		
Wheezing	☐	☐
Shortness of Breath	☐	☐
Coughing	☐	☐
7. GI:		
Rectal Bleeding	☐	☐
Abdominal Pain	☐	☐
Black Tar-Like Stools	☐	☐
8. URINARY:		
Pain with Urination	☐	☐
Involuntary Urination	☐	☐
Decreased Urinary Flow	☐	☐
9.MUSCULOSKELETAL		
Motion Loss	☐	☐
Swelling in Joints	☐	☐
Morning Stiffness	☐	☐
10. INTEGUMENTARY:		
Skin Rash	☐	☐
Skin Lumps	☐	☐
Abrasions	☐	☐
11. NEUROLOGICAL:		
Burning Sensation	☐	☐
Tingling	☐	☐
Sensation Loss	☐	☐
12. PSYCHIATRIC:		
Depressed Feeling	☐	☐
Suicide Attempts	☐	☐
Hallucinations	☐	☐
13. ENDOCRINE:		
Excessive Thirst	☐	☐
Changes in Hair	☐	☐
Excessive Urination	☐	☐
14. HEMATOLOGIC:		
Bleed Easily	☐	☐
Fatigue Easily	☐	☐
Bruise Easily	☐	☐
15. IMMUNOLOGIC:		
Skin Reactions	☐	☐
Eczema	☐	☐
Severe Allergic Reactions	☐	☐

PAST HISTORY:

16. ILLNESSES:	Yes	No
Arthritis (type)_____	☐	☐
Asthma or Bronchitis	☐	☐
Bladder Infection	☐	☐
Blood Clots	☐	☐
Blood Disorders	☐	☐
Blood Pressure Over 130/90	☐	☐
Cancer (type)_____	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
GI Bleeding/ Gastritis/Reflux	☐	☐
Gout	☐	☐
Heart Attack/ Heart Disease	☐	☐
HIV/AIDS	☐	☐
Kidney Stones	☐	☐
Liver Disease/Hepatitis	☐	☐
Lung Disease	☐	☐
Lyme Disease	☐	☐
Neurological Disease	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Parkinsonism	☐	☐
Prostate Enlargement	☐	☐
Pulmonary Embolus	☐	☐
Stroke/Seizures	☐	☐
Thyroid Disease	☐	☐
Ulcers	☐	☐

Other:_____

_____

_____

17. CURRENT MEDICATIONS:

NONE ☐ **DOSE/STRENGTH**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

18. ALLERGIES TO MEDICATION:

NONE ☐

MEDICATION **REACTION**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Primary Care Physician:

Dr._____

Referral source:

_____

Preferred Pharmacy:

_____

_____

19. PAST SURGERIES:	Yes	No
Appendix	☐	☐
Arthroscopy _____	☐	☐
Spine	☐	☐
Breast Biopsy	☐	☐
Cancer (type)_____	☐	☐
Coronary Artery Bypass	☐	☐
Gallbladder	☐	☐
Hysterectomy	☐	☐
Joint Replacement _____	☐	☐
Prostate	☐	☐
Tonsils	☐	☐
Wisdom teeth	☐	☐

20. OTHER HOSPITALIZATIONS:

_____

_____

_____

21. FRACTURES:

_____

_____

22. SOCIAL HISTORY:		
Married	☐	☐
Single	☐	☐
Divorced	☐	☐
Widowed	☐	☐
Presently Living Alone	☐	☐

Number of living Children____

23. SMOKING: Never Smoked ☐

Total yrs._____

Packs per Day_____

Date Stopped_____

24. ALCOHOL USE: Never Drank ☐

Total yrs._____

Drinks/Day_____

Date Stopped_____

25. ILICIT DRUG USE: Never Used ☐

Total yrs._____

Currently Using_____

Date Stopped_____

26. FAMILY HISTORY:		
AIDS	☐	☐
Bleeding Disorders	☐	☐
Cancer	☐	☐
Heart Disease	☐	☐
Mental Illness	☐	☐
Alcoholism	☐	☐
27. Can you climb a flight of stairs?	☐	☐
28. Can you walk a mile?	☐	☐
29. Have you had a DEXA Scan (for bone density)?	☐	☐

If so, when? _____

Weight:_____

Height: _____

The above history was personally reviewed with the patient, and I agree with above.

_____

John T. Moor, MD

Updated 8/15/17

PATIENT INFORMATION FORM

Advanced Sportsmedicine Center
John T Moor, M.D.

TODAY'S DATE: ____/____/____

Who Referred You To Our Office?_____

PATIENT INFORMATION:

FIRST _____FULL MIDDLE_____LAST_____
SS# ____/___/_____ Home # ____-____-_____ Cell # ____-____-_____ Work # ____-____-_____
PermanentAddress:_____City:_____State:____
Zip:_____ E-Mail address _____
SeasonalAddress:_____City:_____State:____Zip:_____
Date of Birth ____/____/____ Age:_____ Sex: Male / Female Marital Status: *(circle)* Single / Married / Other
Employer Name:_____Address:_____
Phone:_____ Fax #:_____

INJURY INFORMATION:

Date of first symptom: ____/____/_____Body Part:_____ *(circle)* Left /Right/Both
Attorney assisting with problem? *(circle)* Yes / No IF yes,whom:_____
Related to: *(circle)* Employment / Auto *(claim #* _____) Other_____

PRIMARY CARE PHYSICIAN:

Physician's Name: _____ Office Phone#: ____-____-_____ Fax#:____-____-_____

INSURANCE INFORMATION – IF PATIENT IS NOT THE POLICY HOLDER

Policy Holder's Name: Last _____First _____
Policy Holder's SS # ____/___/_____ Date of Birth: ____/____/_____ Policy Holder's Phone # ____-____-_____
Policy Holder's Address: _____ State:____ Zip: _____

WORKERS COMPENSATION – TO BE COMPLETED BY STAFF.

W/C Carrier: _____ Claim#_____
Adjuster: _____Phone # ____-____-____ x ____ Fax # ____-____-_____
RN Case Mgr: _____ Phone # ____-____-____ x ____Fax # ____-____-_____
W/C Address: _____City: _____State:____ Zip:_____
Injured Body Part: *(circle)* Left /Right/Both _____ Date of Injury: ____/___/_____
Referring / Previous Physician for this problem: _____
Patient to Bring: XRAY / MR / CT / Med Records/ Other:_____
Doctor to: *(circle)* Evaluate Only / Evaluate & Treat / 2nd Opinion Comments: _____
Appt Date: ____/___/_____ Time: ____:____ Date Contract Faxed: ____/___/_____ Initials: _____

REVISED 5-7-2009

Advanced Sportsmedicine Center

JOHN T. MOOR, MD

Knee and Shoulder Specialist Center

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledge, if you wish. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ DOB _____

Please PRINT your name here

_____ _____

Patient Signature Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individuals you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize you to furnish **John T. Moor, M.D., P.A.** all medical records and other documentation in your possession. I understand these records may contain information from other health care providers, as well as information which is administrative in nature. I specifically consent to the release of any information contained in the medical record which may relate to infection with Human Immunodeficiency Virus (HIV), AIDS, or related conditions. I understand that you have no responsibility for the use or distribution of this information by the party to whom it is released. I release you from all liability which may arise from your compliance with this request to release records. I authorize you to transmit this information by facsimile transmission (Fax) and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission of my records. This release is effective until and unless written notice of revocation is provided to you.

_____ _____

Patient Signature Date

E-PRESCRIBING

Advanced Sportsmedicine Center has implemented e-prescribing as part of an on-going effort to improve your health care. E-prescribing refers to a system used to submit prescriptions electronically to a pharmacy of your choice. By signing below, you provide your consent for Advanced Sportsmedicine Center and its providers to electronically submit your prescriptions through the e-prescribing system and to request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. This consent will remain in effect until you withdraw it. You may withdraw your consent at any time except to the extent it has already been relied upon. Your decision not to sign this form will not affect your ability to receive medical care or your ability to receive your prescriptions through alternative means.

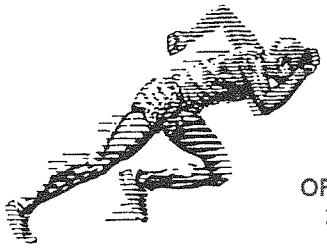
_____ _____

Patient Signature Date

***I decline ☐ The Privacy Practice Handout ☐ Authorization of Medical Record Release ☐ E-Prescribing

_____ _____

Patient Signature Date



ADVANCED
SPORTSMEDICINE
CENTER
John T. Moor, MD, PA
ORTHOPEDIC SPORTS MEDICINE SPECIALIST
2446 S. Tamiami Trail, Sarasota FL 34239

Cancellation Policy/No Show Policy

We understand that there are times when patients must miss an appointment due to an emergency or obligations for work or family. However, when an appointment is not cancelled, another patient may be prevented from getting an appointment they need.

All appointments must be cancelled the previous day to avoid charges for a no-show or late-cancellations. This policy will be taking effect as of April 20, 2015 and will apply to all appointments scheduled.

If an appointment is not cancelled the previous day, your account will be charged a forty dollar ($40) fee; this will not be covered by your insurance company.

The signature of the patient and/or guardian below acknowledges the understanding of the above.

_____

Print Name Patient

_____ _____/_____/_____

Signature Patient/Guardian **Date**