ADULT HISTORY FORM

Advanced Sportsmedicine Center

1.PATIENT NAME:

_____

CHIEF HEALTH CONCERN TODAY:

_____

REVIEW OF SYSTEMS:

2. CONSTITUTIONAL:	**Yes**	**No**
Fever	☐	☐
Unexplained weight loss	☐	☐
Ill feeling	☐	☐
3. EYES:		
Excessive Tearing	☐	☐
Blurred Vision	☐	☐
Dryness	☐	☐
4. CARDIOVASCULAR:		
Ankle Swelling/Pedal Edema	☐	☐
Chest Pain/Angina	☐	☐
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		
Joint Motion Loss	☐	☐
Joints Swelling	☐	☐
Morning Stiffness	☐	☐
10. INTEGUMENTARY:		
Skin Rash	☐	☐
Skin Lumps	☐	☐
Abrasions	☐	☐
11. NEUROLOGICAL:		
Burning Sensation	☐	☐
Tingling Sensation	☐	☐
Sensation Loss	☐	☐
12. PSYCHIATRIC:		
Depressed Feeling	☐	☐
Suicide Attempts	☐	☐
Hallucinations	☐	☐
13. ENDOCRINE:		
Excessive Thirst	☐	☐
Hair Thinning	☐	☐
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	☐	☐
Bladder Infection	☐	☐
Blood Clots	☐	☐
Blood Disorders	☐	☐
Blood Pressure/Hypertension	☐	☐
Cancer (type)_____	☐	☐
Diabetes	☐	☐
Emphysema or COPD	☐	☐
GI Bleed/ Gastritis/Gerd/Ulcer	☐	☐
Gout	☐	☐
Heart Attack/Heart Disease	☐	☐
HIV/AIDS	☐	☐
Hypercholesterolemia/Lipids	☐	☐
Kidney Failure	☐	☐
Liver Problems/Hepatitis	☐	☐
Lyme Disease	☐	☐
Neurological Disease	☐	☐
Osteoporosis	☐	☐
Pacemaker or Defibrillator	☐	☐
Parkinsonism	☐	☐
Prostate Enlargement	☐	☐
Pulmonary Embolus	☐	☐
Stroke	☐	☐
Seizures	☐	☐
Thyroid Disease	☐	☐

Other:_____

_____

Flu Shot	☐	☐
Pneumonia Vaccine	☐	☐

17. CURRENT MEDICATIONS:

NONE ☐

Medication	**Corresponding Illness**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

18. ALLERGIES TO MEDICATION:

NONE ☐

Medication	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Local Primary Care Physician:

Dr._____

Referral source:

_____

Preferred Pharmacy:

_____

19. SURGERIES:	**Yes**	**No**
Appendix	☐	☐
Arthroscopy _____	☐	☐
Spine _____	☐	☐
Breast Biopsy	☐	☐
Cancer (type)_____	☐	☐
Cardiac Bypass or Stenting	☐	☐
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/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 1/1/24

PATIENT INFORMATION FORM

Advanced Sportsmedicine Center

TODAY'S DATE: ____/____/____

Who Referred You To Our Office?_____

PATIENT INFORMATION:

FIRST _____FULL MIDDLE_____LAST_____

SS of patient or guarantor #_____ / _____ / _____ Date of Birth ____/____/____ Age:_____ Sex: Male / Female

Marital Status: *(circle)* Single / Married / Other E-Mail address _____

Home # _____-_____-_____ Cell # _____-_____-_____ Work # _____-_____-_____

Permanent Address: _____ City:_____ State:_____ Zip: _____

Seasonal Address:_____City:_____State:____Zip:_____

PRIMARY CARE PHYSICIAN:

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

Cancellation Policy/No Show Policy

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

All office appointments must be cancelled the previous day (24 hour) to avoid charges for a no-show or with in a week of surgery. This policy will be taking effect as of April 20, 2015 and will apply to all appointments scheduled.

If an office appointment is not cancelled the previous day, your account will be charged a $30 fee. If a surgical procedure is not cancelled 7 days before the scheduled date your account will be charged $250; 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**

Advanced Sportsmedicine Center
JOHN T. MOOR, MD
Knee and Shoulder Specialist Center
Phone: 941-957-1500 Fax: 941-957-3059

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.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.

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.

FINANCIAL AGREEMENT

The undersigned individually obligates him/her and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency fees and expenses. The undersigned understands that Advanced SportsMedicine Center has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

_____ DOB _____

Please PRINT your name here

_____

Patient Signature

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

_____

Patient Signature

PATIENT COMMUNICATION SHEET

Patient Name:_____

Home:_____Work:_____

Date of Birth_____ Cell:_____