Patient Demographics & History Form

Patient Info:

Name: _____ Date: _____

Date of Birth: (mm/dd/yyyy) _____ SSN # : _____

Address:_____

City: _____ State: _____Zip: _____

Phone: Home: _____ Cell:_____

Email: _____

Gender: ▫ Male ▫ Female

Marital Status: ▫ Single ▫ Married ▫ Divorced ☐ Separated ☐ Widowed

---

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Unemployed

Employer Name: _____ Occupation: _____

Employer Address: _____

Employer Phone: _____ School Name: _____

Primary Language Spoken: ☐English ☐Spanish ☐Other _____

Race: ☐ American Indian or Alaska Native ☐Asian ☐Black or African American

☐Native Hawaiian or Pacific Islander ☐White ☐Other _____

Ethnicity: ☐ Hispanic, Latino, or Spanish Origin ☐Not Hispanic, Latino, or Spanish Origin

---

Insurance Info: (Circle all that apply) Insurance - Self Pay - Worker's Comp

Primary Insurance	Secondary Insurance
Provider:_____	Provider:_____
Guarantor: _____	Guarantor: _____
Policy Number: _____	Policy Number: _____
Group Number: _____	Group Number: _____
Date of Birth: _____	Date of Birth: _____
SSN:_____	SSN:_____
INS Address: _____	INS Address: _____

Referral Source / Primary Care Physician

Primary Care Physician Name_____

Referring Physician_____

Emergency Contact

Name_____

DOB_____

Address (if different than above)

_____

City _____ State_____ Zip_____

Contact Relationship _____

Contact Phone Number _____

Parent / Guardian Demographics (if patient is under 19)

Name _____

Phone _____ Cell Phone _____

Address (if different than above) _____

City _____

Date of Birth _____ SSN_____

Authorized persons to schedule and/or transport minor patient:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Chief Complaint

Body Part_____

Date of Injury (if applicable) _____

Occurred: ☐ Car Accident ☐ Fall ☐ Gradual Onset ☐ Sports / Recreational Injury

☐ Unknown ☐ Other_____

Height: _____ Weight: _____ Are you: ☐ Right handed ☐ Left handed

Pain Scale: On a scale of 1-10, rate your pain level when it is at its worst (10 being worst)

10 0 1 2 3 4 5 6 7 8 9

Treatments / Tests since onset symptoms

☐ None	☐ Steroid Injection	☐ CT Scan / MRI	☐ Other / Not Listed
☐ Physical Therapy	☐ Surgery	☐ X-Ray	☐ Medication

Past Medical History

Past and Current Medical Conditions

NONE ☐ Abnormal Heart Rhythm ☐ Alcoholism ☐ Anemia ☐ Anxiety ☐ Asthma ☐

Bleeding Disorders ☐ Blood Clots / DVT ☐ Bronchitis ☐ Cardiac Stent ☐ Cancer ☐

Depression ☐ Diabetes ☐ Emphysema ☐ Endometriosis ☐ Gout ☐ Heart Attack ☐

Heart Failure ☐ Hepatitis Stroke ☐ Thyroid Disease ☐

High Blood Pressure ☐ HIV ☐ Irritable Bowel ☐ Kidney Failure ☐ Kidney Stones ☐

Liver Disease ☐ Stomach Ulcers ☐

Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Seizures ☐ Sleep Apnea ☐

Medications

☐ No Medications

_____

_____

Preffered Pharmacy _____

Drug Allergies

No Drug Allergies ☐ Aspirin ☐ Codeine ☐
Morphine ☐ Penicillin ☐ Sulfa ☐ Contrast Dye ☐ Demerol ☐ Iodine ☐ Latex ☐
Other Allergies (Please List): _____
Reaction: _____
_____

Surgeries or Procedures

☐No Previous Surgeries
Other Surgeries or Procedures and Date

_____
_____
_____
_____

Review of Systems:

Are you experiencing any of the following? (Please circle all that apply)

General: fever chills night sweats loss of appetite unexplained weight loss
Neurologic: loss of balance frequent falls dizziness speech difficulties seizures/ tremors

Cardiovascular: chest pain swelling of legs/ankles rapid/irregular heart beat

Gastrointestinal: nausea/vomiting heartburn abdominal pain blood in stools

Genitourinary: blood in urine frequent bladder infections painfulurination

HEENT: frequent nose bleeds difficulty swallowing chronic headaches

Respiratory: shortness of breath coughing up blood chronic/frequent cough

Eyes: Skin double vision sudden loss of vision

Psychiatric rash anxiety itching

depression other _____

Hematology: swollen glands easily bruise/bleed

Endocrine: excessive thirst/hunger/urination

Family Medical History

Cancer	☐ Father	☐ Mother	☐ Brother	☐Sister
Diabetes	☐Father	☐Mother	☐Brother	☐Sister
Heart Disease	☐ Father	☐Mother ☐Mother	☐Brother ☐Brother	☐Sister ☐Sister
Stroke	☐ Father			☐Unknown

Social History

Smoking Status ☐ Current everyday ☐ Current occasional ☐Former ☐ Never

Alcohol Status ☐ Current everyday ☐ Current occasional ☐Former ☐ Never

Exercise ☐Heavy amount of exercise (4 or more times per week)

☐Moderate amount of exercise (1-3 times per week) ☐Minimal exercise (1 time per week)

☐Active but no formal exercise ☐Never

Receipt of Notice of Privacy Practices

I acknowledge that I was given the opportunity to receive a copy of Sagewell Orthopaedics, Notice of Privacy Practices.

Printed Name

Signature (must be signed by a parent or legal guardian if patient is a minor)

Date

LOCATIONS

LINCOLN | 7350 Willowbrook Lane, Suite 102, Lincoln, NE 68516 | 402.466.0100

SYRACUSE | 2731 Healthcare Drive, Syracuse, NE 68446 | 402.269.2011

NEBRASKA CITY | 115 S. 8TH Street, Nebraska City, NE 68410 | 402.466.0100