7121 Stephanie Lane
Suite 100
Lincoln, NE 68516

Patient Demographics & History Form

Patient Info:

Name: ____ Date: ____________________________
First Middle Last

Date of Birth: (mm/dd/yyyy) ________________ Social Security#: _______________________________

Address: ____

City: ________________________ State: _______________ Zip: ____________________

Phone: Home: ______________________ Cell: __________________________

Email: ____ Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

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Employment Status: □ Employed □ Student □ Retired – Date ________________ □ 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

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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: _________ SSN: _________	Date of Birth: _________ SSN: _________
INS Address: ____________________	INS Address: ____________________

STRASBURGER ORTHOPAEDICS

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Referral Source / Primary Care Physician

Primary Care Physician (First Last) Name____

Referring Physician____

Emergency Contact

Name____ DOB__________________

Address (if different than above) ____

City ___________________ State ___________ ZIP _____________

Contact Phone Number____

Contact Relationship ____

Parent / Guardian Demographics (if patient is under 19)

Name ____

Phone __________________________ Cell Phone _________________

Address (if different than above) ____

City ___________________ State ___________ ZIP _____________

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: _____________________

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STRASBURGER ORTHOPAEDICS
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Medical History Form

Current Symptoms

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)

0 1 2 3 4 5 6 7 8 9 10

Treatments / Tests since onset symptoms

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

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 ☐ High Blood Pressure ☐ HIV ☐ Irritable Bowel ☐ Kidney Failure ☐ Kidney Stones ☐ Liver Disease ☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Seizures ☐ Sleep Apnea ☐ Stomach Ulcers ☐ Stroke ☐ Thyroid Disease ☐ Tuberculosis ☐ Other____

Medications

☐ No Medications

____

____

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____

Preferred Pharmacy______________________________

Drug Allergies

□ No Drug Allergies □ Aspirin □ Codeine □ Contrast Dye □ Demerol □ Iodine □Latex □Morphine □Penicillin □Sulfa

□Other Allergies (Please list) ____________________

Allergy 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

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Genitourinary: blood in urine frequent bladder infections painful urination

HEENT: frequent nose bleeds difficulty swallowing chronic headaches

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

Eyes: double vision sudden loss of vision

Skin: rash itching

Psychiatric: anxiety 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	□ Brother	□ Sister
Stroke	□ Father	□ Mother	□ Brother	□ Sister

□ Other ____ □ 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

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Receipt of Notice of Privacy Practices

I acknowledge that I was given the opportunity to receive a copy of Syracuse Area Health, Notice of Privacy Practices.

Printed Name

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

________________________________ Date