PATIENT REGISTRATION

Patient Name ______________________________
Last First Middle Initial (Nickname)

Home Address ______________________________
Street Apt.#

____
City State Zip

Home Phone ( ) ________________ Cell Phone ( ) ________________

Emergency Contact ________________ Emergency Phone ( ) ________________

☐ Male ☐ Female Body part being evaluated ________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/er

Birth date:____/____/____Age:________________ Social Security # ________________

E-Mail ______________________________

Race: ____________Language: ____________ Ethnicity: ____________

Primary Care Physician: ________________ Phone# ( ) ________________

Referred by (Dr./Patient/Friend): ______________________________

Ref erred By Attorney? ________________ Phone# ( ) ________________

Patient's Employer/School: ________________ Phone# ( ) ________________

BILLING INFORMATION

PRIMARY INSURANCE

Ins. Co. Name:________________

Subscriber Name: ________________

Date of Birth: ________________

Policy#: ________________

Group#: ________________

Employer: ________________

SECONDARY INSURANCE

Ins. Co. Name:________________

Subscriber Name: ________________

Date of Birth: ________________

Policy#: ________________

Group#: ________________

Employer:________________

Does your insurance carrier require a referral? ☐ Yes ☐ No

Is this a labor and industries claim? ☐ Yes ☐ No

Signature ______________________________ Date ________________

EvergreenHealth Kirkland, WA 98034

PATIENT REGISTRATION

FORM ID ORTHO 145

Approved 06/14

APPLY PATIENT LABEL HERE

MR

ORTHOPEDIC HEALTH HISTORY FORM

Name:		DOB:	Date:
Height:	Weight:	Age:	**BMI:**

Nutrition status	Recent weight Gain ☐ YES ☐ NO Weight loss in last 6 months ☐ YES ☐ NO How much: ____ (lbs) Were you trying to lose weight? ☐ YES ☐ NO Loss of appetite? ☐ YES ☐ NO Have you eaten less than normal over the past three months? ☐ YES ☐ NO • If yes, "is this because of chewing, or swallowing difficulties? ☐ YES ☐ NO
Social History Habits	**Do you currently smoke cigarettes? ☐ YES ☐ NOT CURRENTLY ☐ NEVER** For how many years?_________ When did you quit?________ How many packs of cigarettes per day?________________ How many years did you smoke before quitting?__________ Do you currently use smokeless tobacco? ☐ YES ☐ NO Use Cigars? ☐ YES ☐ NO **Have you smoked/chewed tobacco within the past 4 weeks?** ☐ YES ☐ NO Do you use **alcohol**? ☐ YES ☐ NO If yes, Avg. # drinks per week? _______ Do you use **drugs**? ☐ YES ☐ NO (examples Marijuana, cocaine, Heroin, other)_____ Date of recent/last use? _______________ You live: ☐ Alone ☐ w/Spouse ☐ w/Family ☐ Assisted living ☐ Nursing facility ☐ State facility
Family History	☐ Diabetes ☐ hypertension ☐ coagulation problems ☐ Arthritis ☐ Cardiovascular disease ☐ Cancer Type: ___________________ ☐ **NONE**
Medications and supple-ments'	**CURRENT MEDICATIONS:** (Please list of all medications, vitamins, supplements, drops you are currently taking; including herbal supplements) bring separate list if space inadequate: ☐ **NONE** ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________
Allergies:	Please list ALL MEDICATION, drug, food or environmental Allergies: (examples penicillin, latex, Tape, Band-Aids, nuts, eggs, shellfish, bees, pollen, grass): ☐ **NONE** ______________________ ______________________ ______________________ ______________________ ______________________ ______________________

APPLY PATIENT LABEL HERE

MR

ORTHOPEDIC HEALTH HISTORY FORM

Name:	DOB:	Date:

Surgical History	Prior Surgeries(bring separate list if space inadequate, include dates): ☐ **NONE** ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ **Prior difficulty with anesthesia or surgery?** ☐ YES ☐ NO **Nausea/vomiting after surgery?** ☐ YES ☐ NO **Do you have any history with Malignant Hyperthermia?** ☐ YES ☐ NO **Difficult Intubation?** ☐ YES ☐ NO	
General	☐ Fever/chills/night sweats ☐ Need mobility assistance (cane, walker) ☐ **NONE**	☐ History of MRSA ☐ History of HIV ☐ **NONE**
Eye Problems	☐ Vision Problems ☐ Contacts ☐ Glasses ☐ **NONE**	☐ Glaucoma ☐ Vision 20/70 or worse ☐ **NONE**
Ear/Nose/ Throat	☐ Difficulty hearing ☐ Sinus Problems ☐ Dentures ☐ Sore throat ☐ **NONE**	☐ Difficulty swallowing ☐ **NONE**
Heart Problems:	☐ Chest pain or angina ☐ Heart surgery ☐ Heart attack ☐ Blockages in arteries ☐ Ankle swelling ☐ Heart stents ☐ Aortic aneurysm ☐ Heart valve disease ☐ Heart murmur ☐ Atrial fibrillation ☐ Defibrillator (AICD) ☐ Heart failure ☐ Pacemaker ☐ Irregular heartbeat ☐ Angioplasty ☐ **NONE**	☐ **Leg/ankle/foot Swelling** ☐ High blood Pressure ☐ Prior EKG When: ___________ Where: __________ ☐ **NONE**
Lung Problems:	☐ Asthma ☐ Emphysema ☐ COPD ☐ Tuberculosis in last year ☐ Pneumonia in last 3 months ☐ Pulmonary hypertension ☐ Cold or flu in last week ☐ Frequent cough ☐ Wheezing ☐ Bronchitis ☐ **NONE**	☐ Shortness of breath when lying on back ☐ Use Oxygen at home ☐ Regular Inhaler use ☐ **NONE**
Sleep Problems:	☐ Snoring ☐ Daytime drowsiness ☐ Sleep apnea ☐ **NONE**	☐ CPAP ☐ **NONE**
Liver, intestinal or Stomach Problems:	☐ Active Crohn's ☐ Active Ulcerative Colitis ☐ Hepatitis ☐ Hiatal hernia ☐ Liver transplant ☐ Blood in stool ☐ Constipation ☐ Black/tarry stool ☐ Bowel Incontinence ☐ Recent stomach ulcer ☐ Reflux or GERD ☐ Diarrhea ☐ **NONE**	☐ **Liver Disease/ impairment** ☐ Nausea ☐ Vomiting ☐ **NONE**
Urinary or Kidney	☐ One kidney ☐ Dialysis ☐ Blood in urine ☐ Kidney transplant ☐ Frequent Urination ☐ Incontinence ☐ Dribbling ☐ Gallstones ☐ Trouble initiating stream ☐ Kidney stones ☐ Burning or painful urination ☐ **NONE**	☐ **Impaired kidney function** ☐ GRF___________ ☐ **NONE**

ORTHOPEDIC HEALTH HISTORY FORM

Name:	DOB:	Date:

Problems: Endocrine Problems:	☐ Adrenal problems ☐ Thyroid disease ☐ Excessive thirst ☐ Heat intolerance ☐ Gout ☐ Pituitary problems ☐ Take prednisone or other steroids ☐ Cold intolerance ☐ Pancreatitis ☐ **NONE**	☐ **Diabetes** ☐ Insulin Use ☐ HgA1C in last 3 months Level: ________ ☐ **NONE**
Nervous System Problems:	☐ Brain aneurysm ☐ Multiple sclerosis ☐ Spinal cord injury ☐ Myasthenia Gravis ☐ Headaches ☐ Muscle weakness ☐ RSD ☐ Brain tumor ☐ Lupus ☐ Parkinson's ☐ Muscular Dystrophy ☐ lightheaded/dizzy ☐ Forgetful/Memory loss ☐ **NONE** ☐ Tremors ☐ Paralysis	☐ Seizure disorder/ epilepsy ☐ Stroke or TIA ☐ Numbness/tingling or burning in arms, hands, legs or feet ☐ Balance problems ☐ **NONE**
Skin Problems:	☐ Active Shingles ☐ Itching ☐ Growing lesion ☐ New Rash ☐ Hair loss ☐ Sores/ulcers ☐ Psoriasis ☐ Athletes foot ☐ **NONE**	☐ Eczema ☐ Open wound ☐ **NONE**
Bleeding or Clotting Disorder:	☐ Hemophilia ☐ Bleed or bruise easily ☐ Sickle Cell Disease ☐ Peripheral vascular disease ☐ Bleeding Disorder ☐ Anemia ☐ Recent Blood transfusion ☐ Blood clots ☐ **NONE**	☐ Use blood thinner medications ☐ Coumadin, Plavix, Aspirin ☐ History of DVT ☐ **NONE**
Cancer	☐ Active Leukemia ☐ Active lymphoma ☐ Amyloidosis ☐ Multiple Myeloma ☐ Radiation Therapy in last 6 weeks ☐ **NONE**	☐ Chemotherapy in last 6 weeks ☐ Lymph node involvement ☐ **NONE**
Psychiatric	☐ Depression ☐ PTSD ☐ Schizophrenia ☐ Loss of interest in activities ☐ Anxiety ☐ Bipolar ☐ Frequently sad or blue ☐ **NONE**	☐ **Dementia** ☐ Alzheimer ☐ **NONE**
Gynecologic	☐ Normal Menstrual Cycle ☐ Breast pain ☐ Hot Flashes ☐ Menopause ☐ Breast discharge ☐ Preeclampsia ☐ **NONE**	Pregnant ☐ YES ☐ NO ☐ Unsure
Musculo-skeletal	☐ Back pain ☐ Joint swelling ☐ Rheumatoid arthritis ☐ Paget's Disease ☐ Joint pain ☐ Joint stiffness ☐ Osteoporosis ☐ Fibromyalgia ☐ **NONE**	☐ Neck pain ☐ Neck stiffness ☐ **NONE**

APPLY PATIENT LABEL HERE

MR

ORTHOPEDIC HEALTH HISTORY FORM

Name:	DOB:	Date:

Intake form reviewed and confirmed with patient ☐ YES ☐ NO

PATIENT SIGNATURE: ______________________ DATE: ______________

DR. SIGNATURE: ______________________ DATE: ______________

APPLY PATIENT LABEL HERE

ORTHOPEDIC HISTORY FORM

Name: ______________________________ DOB: ____________ Date: ________________

Location of problem(s): ____________________________________ Onset Date: ____________

Please briefly describe how problem started (injury, gradual onset): ________________________

____

Any previous surgery at problem site? ☐ Yes ☐ No

Previous surgery date: __________________ Surgeons name: ____________________________

INJURY/SYMPTOMS:

Did you fell/hear a pop or tear? ☐ Yes ☐ No

Did your Joint pop out? ☐ Yes ☐ No

Did you continue the activity? ☐ Yes ☐ No

Does it feel loose/unstable? ☐ Yes ☐ No

Current Symptom/Complaints:

Pain: Severity 0-10 ___________

Type: Achy Dull Sharp Numb Tingling Burning Cramp Tired Stabbing Lancing

Frequency: Rare Occasional Intermittent Frequent Constant

Aggravated by: Lift Carry Reach Push Pull Overhead Throw
Walk Squat Kneel Stairs Twist Hill/incline Jump Run

Stiffness: None Occasional Intermittent Frequent Constant

Swelling: None Occasional Intermittent Constant [Mild Moderate Severe]

Weakness: ☐ Yes ☐ No Where? ________________________________

Giving way/Buckling? None Rare Occasional Intermittent Frequent Constant

Have you fallen because of weakness/buckling? ☐ Yes ☐ No

Grinding/Grating? None Rare Occasional Intermittent Frequent Constant

Popping/Catching? None Rare Occasional Intermittent Frequent Constant

Locking? None Rare Occasional Intermittent Frequent Constant

Nighttime Pain? ☐ Yes ☐ No Pain Interrupts sleep? ☐ Yes ☐ No

ADL: Does your problem interfere with? Driving Shopping Cooking Eating
Cleaning Toileting Dressing Grooming Bathing Laundry
Work School Exercise

APPLY PATIENT LABEL HERE

MR

PRIOR TEATMENT:

Did you see a physician? ☐ Yes ☐ No Provider, Clinic or Hospital name: ___________

Where x-rays taken? ☐ Yes ☐ No

Did you have an MRI, CT or other? ☐ Yes ☐ No

Medications prescribed? ☐ Yes ☐ No Narcotics? ☐ Yes ☐ No

NSAIDS e.g. Ibuprofen, Aleve? ☐ Yes ☐ No

Physical Therapy? ☐ Yes ☐ No **Where:** ___________________________

When: ☐ Greater than 3 months ago ☐ Less than 3 months ago

Injections? ☐ Yes ☐ No ☐ Steroid ☐ Euflexxa ☐ Synvisc ☐ Orthovisc ☐ Other

Braces? ☐ Yes ☐ No

Other treatment? ___________________________________

Which Statement(s) best describe your usual level of activity:

- ☐ I am able to run, swim, play tennis, play basketball, ski **(≥10 METS)**;
- ☐ I am able to perform climb stairs, walk up a hill, yard work (ex: raking leaves, mowing the grass with a push mower) **(5-8 METS)**;
- ☐ I am able to perform light house work (ex: dusting, sweeping, some vacuuming), grocery shopping, walking **(≤4 METS)**;
- o I am able to perform limited activities (ex: dressing, bathing, preparing meals, self-feeding) or (≤ 1 MET).
- o I need assistance with bathing, toileting, dressing, feeding, and/or I am bedbound.

Intake form reviewed and confirmed with patient

PATIENT SIGNATURE: ___________________________ DATE: _______________

PHYSICIAN SIGNATURE: ___________________________ DATE: _______________

APPLY PATIENT LABEL HERE

MR

Patient Name: ____ Birth Date: ____________________
Please Print

Please read the following and complete the information requested

You have the right to identify individuals other than your health care providers who are involved in your care (family, friends, or others). We may verbally share your medical information to an individual you have identified as involved in your medical care. We may also give information to someone who helps pay for your care. EvergreenHealth will only share your health information with the individuals you designate, except as required or permitted by law. You may add or change this list at any time.

Information related to Mental Health, Chemical Dependency, or HIV testing and/or therapy will only be shared with you unless specifically authorized below. (Sensitive Information)

☐ **I DO NOT authorize EvergreenHealth to verbally share information with anyone.**

I authorize EvergreenHealth to verbally share medical information/billing information with the individuals listed below:

Name	Relationship to Patient	Information to Share
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:________________________
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:________________________
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:________________________

I agree I may be contacted for appointments or follow-up information about my care at the following numbers:

Primary contact #________________________ Ok to leave detailed message? ☐ Yes ☐ No

Secondary contact # ______________________ OK to leave detailed message? ☐ Yes ☐ No

These designations will remain in effect indefinitely or until otherwise revoked by me in writing.

Signature: ____ Date: ____________________
(if signed by a personal representative of the patient, please complete the following:)

Personal Representative's Name: ____
Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Holder of a Medical Power of Attorney*
* Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

Patient Name:____ Birth Date:_______________________

By signing this form, you acknowledge receipt of the EvergreenHealth Notice of Privacy Practices. It does not signify that you have read, understand or agree with the Notice. The EvergreenHealth Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full Notice.

I hereby acknowledge that I have received a copy of the EvergreenHealth Notice of Privacy Practices.

Signature: ____ Date: _______________________

(if signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: ____

Relationship to Patient: ☐Parent ☐Legal Guardian* ☐Holder of a Medical Power of Attorney*

*Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

FOR EVERGREENHEALTH USE ONLY

Documentation of Attempt to Obtain Written Acknowledgment of the Delivery of the Notice of Privacy Practices

I delivered EvergreenHealth's Notice of Privacy Practices to this patient or his/her personal representative, but was unable to obtain an acknowledgment of the receipt of EvergreenHealth's Notice of Privacy Practices because:

☐Patient was unable to sign
Reason: ____

☐Patient refused to sign

☐Notice of Privacy Practice/Acknowledgment was mailed to patient

Employee Name: ____ Department: _________________

Employee Signature: _____________________________________ Date: _______________________

EvergreenHealth Kirkland, WA 98034

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FORM ID ADM 538

Approved 07/13
Item ID I101678

APPLY PATIENT LABEL HERE

Original - Medical Record Copy - Patient

MR

CONSENT FOR CARE

MEDICAL TREATMENT: I, the undersigned, hereby consent to and permit my health care team to provide treatment and care as may be deemed necessary, including but not limited to tests, examinations, anesthetics and other medications, immunizations, x-rays, and medical and surgical treatment and other treatments, including HIV tests in the event of an exposure at EvergreenHealth. Your health care team consists of medical doctors, doctors in training (residents), nurses, other health care professionals, and students of the health sciences. I understand that my care is under the control of my attending physicians who may or may not be employees or agents of EvergreenHealth, but rather, independent physicians. The Hospital is not liable for independent physicians and their acts or omissions or any acts or omissions occurring from following their instructions. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made to me as to the result of treatment or examination in the hospital.

PHOTOGRAPHS: Photographs, videotapes, or other images of you may be used in connection with your diagnosis, care and treatment (including surgical procedures) at EvergreenHealth. These images may become part of your medical record.

PERSONAL VALUABLES: I understand if I am admitted to the hospital, the hospital maintains a safe for the safekeeping of money and valuables of small size, and that the hospital shall not be liable for loss or damage to any money, jewelry, glasses, dentures, documents, or other small articles of value unless placed in the safe, and shall not be liable for loss or damage to any other personal property unless deposited with the Hospital for safekeeping.

FINANCIAL AGREEMENT

FINANCIAL AGREEMENT: I agree, whether I sign as representative or as patient, that in consideration of the services to be rendered to the patient, I agree to be personally responsible for the balance due after any applicable insurance payment(s). I understand and agree to the following:

- Should the account be referred to a third party for collection, the amount due shall include all reasonable attorney's fees, collection expenses, and interest.
- In the event I am undersigning as representative for the patient, I personally assume liability for the patient responsibility amount.
- If I am married, the marital community is hereby obligated for the patient responsibility amount.
- EvergreenHealth may verify my employment and financial information for the purpose of determining my ability to pay the patient responsibility amount and/or my eligibility for charity care.
- I understand that if I do not notify EvergreenHealth of changes in my insurance coverage I may be held financially responsible for the service provided.

I certify that I have read this form, including the additional financial agreement information on the back, and/or had it explained to me and that I understand its content. I certify that as the patient or his/her legal representative or legal guardian, I accept the terms of this document.

Patient: ______________________ ______________________ Date:__________
Signature Printed Name

Parent/Guardian: ______________________ ______________________ Date:__________
Signature Printed Name

Kirkland, WA 98034

CONSENT TO CARE &
FINANCIAL AGREEMENT

FORM ID ADM 100

Approved 03/14

APPLY PATIENT LABEL HERE

Original – Medical Record Copy – Patient

MR

CHARITY CARE: EvergreenHealth is committed to the provision of medically necessary health care services to all persons in need of such services regardless of ability to pay. The patient responsibility amount for persons meeting medical indigency criteria as outlined in WAC 246-453 may be waived or reduced. Please contact **Patient Financial Services at (425) 899-1616** to obtain information about this and/or other assistance programs available.

INSURANCE: EvergreenHealth requires each patient to present his or her healthcare insurance card at (or shortly following) the time service is provided at EvergreenHealth. If the patient or insured fails to provide a copy of the insurance card and the insurance carrier or HMO denies payment or coverage because EvergreenHealth is a non-contracted provider, EvergreenHealth will hold me responsible for payment of my bill. EvergreenHealth will not be responsible for any financial penalties assessed by the insurance carrier.

You are responsible for payment of your account. EvergreenHealth cannot accept responsibility for negotiating a settlement on a disputed claim. You will be notified if insurance payments are not received promptly.

1. **PAYMENT POLICY:** Payment for services is due when a bill or statement identifying the patient's personal amount owed is presented. As a service to our patients, EvergreenHealth will bill health care insurance carriers when patients provide complete billing information. When the insurance payment is received, EvergreenHealth will send a statement identifying any personal amount owed. If insurance payment is not received within 60 days, the entire bill may become the patient's responsibility.
2. **DEPOSIT REQUIREMENTS:** EvergreenHealth reserves the right to require deposits and co-pays in advance of or at the time services are rendered.

PROVIDER BASED CLINICS: I understand that patients who receive outpatient services on the EvergreenHealth Campus as well as, Senior Health Clinic and the Sleep Clinic generally receive two bills: one bill from the physician or other provider (for the costs of the professional services) and one bill from the hospital (for the facility costs, i.e. building, equipment, supplies, staff time). Each of these bills may incur a co-payment or co-insurance responsibility, depending on my insurance coverage. The exact amount of the co-insurance or co-payment will depend upon the actual services provided and the coverage provisions of any insurance I have.

ESTIMATED CHARGES: At my request, staff will provide me with an estimate of the billed charges for services I am likely to receive.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to EvergreenHealth for benefits otherwise payable to me for the period of hospitalization and/or period of treatment.

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under the appropriate titles of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

REVIEW OF SYSTEMS

HEENT (Head, Eyes, Ears, Nose, Throat)			NEUROLOGIC		
☐ YES	☐ NO	Headache	☐ YES	☐ NO	Numbness
☐ YES	☐ NO	Hard of hearing I Hearing aid	☐ YES	☐ NO	Balance problems
☐ YES	☐ NO	Dentures I Caps I Loose teeth	☐ YES	☐ NO	Seizures
☐ YES	☐ NO	Jaw I Neck, range of motion	☐ YES	☐ NO	Weakness
☐ YES	☐ NO	Vocal cord problems	☐ YES	☐ NO	Memory loss
☐ YES	☐ NO	Eye trauma	☐ YES	☐ NO	Stroke
☐ YES	☐ NO	Double vision	☐ YES	☐ NO	Psychiatric problems

HEENT (cont.)			SKIN					
☐ YES	☐ NO	Contact Lenses I Glasses						
RESPIRATORY			☐ YES	☐ NO	Lesions	☐ YES	☐ NO	Eczema
☐ YES	☐ NO	Recent cold / cough	☐ YES	☐ NO	Rash	☐ YES	☐ NO	MRSA (Active)
☐ YES	☐ NO	Wheezing	☐ YES	☐ NO	Scars	☐ YES	☐ NO	HX of MRSA
☐ YES	☐ NO	Shortness of breath/Asthma/COPD/TB	☐ YES	☐ NO	Masses			

CARDIOVASCULAR			URINARY		
☐ YES	☐ NO	Murmur/ Irregular rhythm	☐ YES	☐ NO	Renal failure
☐ YES	☐ NO	Pacemaker / AICD	☐ YES	☐ NO	Hesitancy
☐ YES	☐ NO	Congestive failure	☐ YES	☐ NO	Pain
☐ YES	☐ NO	Swelling of ankles	☐ YES	☐ NO	Incontinence
GASTROINTESTINAL			☐ YES	☐ NO	Kidney stones
☐ YES	☐ NO	Reflux Heartburn	☐ YES	☐ NO	Bladder infections
☐ YES	☐ NO	Ulcers / Gerd	**METABOLIC**		
☐ YES	☐ NO	Liver problems / Hepatitis / Jaundice	☐ YES	☐ NO	Weight gain
☐ YES	☐ NO	Nausea / Vomiting / Motion Sickness	☐ YES	☐ NO	Thyroid problem
☐ YES	☐ NO	Diarrhea	☐ YES	☐ NO	Nutritional problem
☐ YES	☐ NO	Communicable diseases	☐ YES	☐ NO	Weight loss
☐ YES	☐ NO	Constipation / Pain	☐ YES	☐ NO	Fatigue
☐ YES	☐ NO	Blood in stool			

FAILED CONSERVATIVE MANAGEMENT

Have you tried antiinflammatory? ☐ YES ☐ NO ____________________ Have you tried weight loss? ☐ YES ☐ NO

Have you tried PT? ☐ YES ☐ NO ____________________ Have you tried braces? ☐ YES ☐ NO

Have you had injections? ☐ YES ☐ NO ____________________ Have you tried a cane? ☐ YES ☐ NO

FAMILY HISTORY

☐ YES	☐ NO	Blood Clots/Bleeding Disorder	☐ YES	☐ NO	Heart Disease
☐ YES	☐ NO	Cancer	☐ YES	☐ NO	High Blood Pressure I Hypertension
☐ YES	☐ NO	Diabetes	☐ YES	☐ NO	Sleep Apnea
☐ YES		Other ________________________	☐ YES	☐ NO	MRSA

PRINT PATIENT NAME: ____ D.O.B. ____

PATIENT SIGNATURE: __________________ DATE: __________________ DR. SIGNATURE: _________________ DATE: ________

REVIEWED BY PATIENT: _______________ (Initial Date) REVIEWED BY PATIENT: ____________ (Initial Date) REVIEWED BY PATIENT: ______________ (Initial Date)

REVIEWED BY DOCTOR: _______________ (Initial Date) REVIEWED BY DOCTOR: ____________ (Initial Date) REVIEWED BY DOCTOR: ______________ (Initial Date)

ASC REVIEWED BY: ____ DATE: ____________________________

EvergreenHealth Kirkland, WA 98034

PATIENT HEALTH HISTORY FORM

FORM ID ORTHO 155

Approved 06/14

APPLY PATIENT LABEL HERE

MR