HOSPITAL FOR SPECIAL SURGERY
SAM TAYLOR MD
ORTHOPAEDIC SURGERY & SPORTS MEDICINE
www.SamTaylorMD.com

Stamford Office
1 Blachley Road
Stamford, CT 06902
Tel: 203.705.0750
Fax: 203.705.2929

Manhattan Office
535 East 70th Street
New York, NY 10021
Tel: 646.714.6324
Fax: 646.714.6378

Health History Form

Today's Date: _____
Name: _____
Age: _____ DOB: _____
Hand dominance: ☐Right ☐ Left
Sex: ☐Male ☐ Female

Reason for Visit:

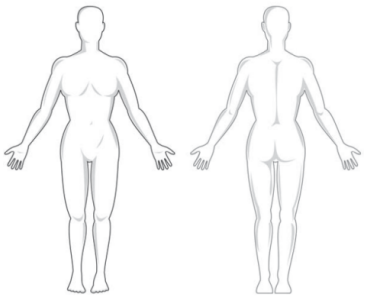
Side: ☐ RIGHT ☐ LEFT ☐ BOTH
Body Part: ☐ Shoulder ☐ Elbow ☐ Knee ☐ Other (List): _____

Describe Injury (2-3 sentances):

Work Injury: ☐Yes ☐No
Auto Accident: ☐Yes ☐No
Open legal case relates to injury: ☐Yes ☐No

PAIN DRAWING AND RATING SCALE:

Please mark the drawing by using X's, lines or circles to indicate where you feel pain right now.



Key
X=Pain
O=Numbness/Tingling

Rate your Pain
Right now (0=none, 10=worst): ☐0 ☐1 ☐2☐3☐4☐5☐6☐7☐8 ☐9 ☐10
At worst (0=none, 10=worst): ☐0 ☐1 ☐2☐3☐4☐5☐6☐7☐8 ☐9 ☐10

Onset: ☐ Gradual ☐ Sudden
Duration: _____ ☐ Days ☐Weeks ☐ Months ☐ Years List Date: _____
Frequency: ☐constant ☐intermittent ☐only with activity ☐other
Quality: ☐sharp ☐ dull ☐burning ☐tingling ☐throbbing ☐other
Night pain: ☐yes ☐no
Swelling: ☐yes ☐no
Feels unstable/gives way: ☐yes ☐no
Mechanical symptoms: ☐popping ☐clicking ☐catching ☐locking ☐grinding
Range of motion: ☐normal ☐ decreased
Everyday activities: ☐no restrictions ☐ limited ☐ unable
Recreational activities: ☐no restrictions ☐ limited ☐ unable

Previous treatments

Anti-inflammatory medications (Advil, Aleeve, etc.): ☐yes ☐no
Narcotic pain medicine (Vicodin, Percocet, etc.): ☐yes ☐no
Injections (steroid, Orthovisc, Synvisc, Euflexxa, other) : ☐yes ☐no
Physical therapy: ☐yes ☐no When: _____

Previous operations on this part of the body:

Date:	Surgeon:	Procedure:
_____	_____	_____
_____	_____	_____

Past Medical History (check all that apply): ☐ NO MEDICAL PROBLEMS

☐Alzheimer's disease
☐Anemia
☐Angina
☐Anxiety
☐Asthma
☐Atrial fibrillation
☐Blindness
☐Blood clot (DVT, PE)
☐Blood transfusion
☐Bronchitis
☐Cancer
☐Cellulitis
☐COPD
☐Cirrhosis
☐Claustrophobia
☐Clotting disorder
☐Coagulation defect
☐Colitis
☐Concussion
☐Congestive Heart Failure (CHF)
☐Coronary Artery Disease (CAD)
☐Cerebral Vascular Accident
☐Deafness
☐Depression
☐Diabetes, Type I
☐Diabetes, Type II
☐Diabetic neuropathy
☐Dialysis
☐Emphysema
☐Epilepsy
☐GERD (Reflux)
☐Gall bladder disease
☐Glaucoma
☐Gout
☐Hay fever
☐Heart attack (MI)
☐Heart murmur
☐Hepatitis,
☐Hypertension (high blood pressure)
☐HIV/AIDS
☐Irregular heart beat
☐Joint pain
☐Kidney disease, chronic
☐Kidney stones
☐Migraines
☐Mitral valve prolapse
☐Musculoskeletal deformities, congenital
☐Neuropathy
☐Organ Transplant, Type _____
☐Pacemaker
☐Panic disorder
☐Parkinson's disease
☐Pneumonia
☐Prostate disease
☐Pulmonary embolism
☐Rheumatoid Arthritis (RA)
☐Seizure
☐Sickle_ cell trait
☐Sleep apnea (OSA)
☐Stroke
☐Thrombophlebitis
☐Thyroid disease
☐Traumatic Brain Injury (TBI)
☐Tuberculosis (TB)
☐Ulcerative colitis
☐Ulcers
☐Urinary tract infection
☐Other, List _____

Surgical History (check all that apply): ☐ NO PREVIOUS SURGERY

☐ Ankle
☐ Appendectomy
☐ Arm
☐ Back
☐ Breast
☐ Colon
☐ Ear/Nose/Throat
☐ Elbow
☐ Eye
☐ Finger
☐ Foot
☐ Gallbladder
☐ Hand
☐ Head
☐ Heart
☐ Hernia
☐ Hip
☐ Hysterectomy
☐ Knee
☐ Lung
☐ Neck
☐ Reproductive
☐ Shoulder
☐ Skin
☐ Spine
☐ Stomach
☐ Thigh
☐ Thyroid
☐ Toe
☐ Tonsillectomy
☐ Urologic
☐ Vascular
☐ Wrist
☐ Other, List _____

Family Medical History (check all that apply): ☐ NO FAMILY MEDICAL PROBLEMS/HISTORY UNKNOWN

☐ Arthritis
☐ Bleeding disorder
☐ Clotting disorder
☐ Cancer
☐ Diabetes
☐ Heart attack
☐ Hypertension
☐ Leukemia
☐ Lung disease
☐ Reaction to anesthesia
☐ Stroke
☐ Malignant Hyperthermia
☐ Other, List _____

Review of Systems (check all that apply): ☐ **NONE OF BELOW**

Constitutional	☐ Fever/Chills	☐ Weight loss	☐ Change in appetite	☐ Night Sweats
	☐ Nausea/Vomiting	☐ Fatigue/Lethargy	☐ Other	
Eyes	☐ Visual changes	☐ Blindness	☐ Cataracts	☐ Other
HEENT	☐ Hearing change	☐ Deafness	☐ Toothache	☐ Vertigo
	☐ Ringing (tinnitus)	☐ Sinusitis	☐ Gingival bleeding	☐ Other
Cardiovascular	☐ Chest pain	☐ Irregular heartbeat	☐ Leg swelling	☐ Palpitations
	☐ Decreased exercise	☐ Other		
Respiratory	☐ Shortness of breath	☐ Chronic cough	☐ Bloody sputum	☐ Sleep apnea
	☐ Asthma	☐ Wheeze	☐ Pulmonary emboli	☐ Other
Gastrointestinal	☐ Bowel changes	☐ Anorexia	☐ Bloody stools	☐ Abdominal pain
	☐ Nausea/vomiting	☐ Black tarry stools	☐ Heartburn	☐ Diarrhea
	☐ Constipation	☐ Difficulty swallowing	☐ Other	
Genitourinary	☐ Incontinence	☐ Painful urination	☐ Frequent UTI's	☐ Other
Integumentary	☐ Pigment changes	☐ Keloids	☐ Breast lump	☐ Rashes
	☐ Open wounds	☐ Breast discharge	☐ Itching	☐ Other
Neurologic	☐ Headaches	☐ Stroke	☐ Gait/balance change	☐ Neuropathy
	☐ Tremors	☐ TIA's	☐ Seizures	☐ Other
Musculoskeletal	☐ Joint pain	☐ Joint stiffness	☐ Weakness	☐ Muscle pain
	☐ Osteoporosis	☐ Osteopenia	☐ Other	
Endocrine	☐ Weight loss	☐ Weight gain	☐ Hair loss	☐ Cold intolerance
	☐ Heat intolerance	☐ Mood swings	☐ Other	
Psychiatric	☐ Depression	☐ Anxiety	☐ Confusion	☐ Poor body image
	☐ Lack of energy	☐ Psychiatric diagnosis	☐ Bipolar	☐ Other
Hematologic	☐ Anemia	☐ Easy bruising	☐ Easy bleeding	☐ Blood clots
	☐ Use of blood thinner	☐ Blood transfusion	☐ Lymph node enlargement	☐ Other
Immunologic	☐ Frequent illness	☐ Seasonal allergies	☐ Allergic dermatitis	☐ Other

Allergies:

☐ **NO KNOW DRUG ALLERGIES**

☐Drug: Name of Drug: _____ Reaction: _____

☐Other: (adhesives, latex, shellfish, contrast dye, other): _____

Current Medications:

☐ **NO MEDICATIONS**

Name of Drug:	Dose:	Duration:	Reason for taking drug:

Social History:

Occupation:_____ Employer:_____

Sport/Position:_____ Team/School:_____

Marital status: ☐married ☐ single ☐ widowed ☐ divorced

Number of children: ☐0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or ☐ more

Do you smoke cigarettes: ☐yes ☐no # packs per day?_____ Years? _____

Did you previously smoke cigarettes: ☐yes ☐ no # years? _____

Quit date?_____ Do you use smokeless tobacco: ☐yes ☐ no

Do you drink alcohol: ☐yes ☐ no drinks per week? _____

Do you use any illicit/recreational drugs: ☐yes ☐ no List Drugs:_____

Level of activity: ☐inactive light ☐ moderate ☐ vigorous ☐ intense

Types of activity (list):_____

Females Only: Gynecological History

Are you pregnant at this time? ☐yes ☐ no ☐ maybe

Do you use birth control? ☐yes ☐ no If yes what type? _____

Have you experienced menopause or hysterectomy? ☐yes ☐ no If yes, date _____

Date of last pap smear: _____

Date of last mammogram: _____

Age at first menstrual period: _____

Most recent menstrual period: _____

How many periods have you had in the last 12 months: ☐none ☐ 1-4 ☐5-6 ☐7-9 ☐ 10-12

Number of pregnancies: ☐0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or ☐ more

Please list any specific questions you would like to discuss today:

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Patient Consent to Treatment

I, _____.understand that I am suffering from a condition requiring diagnostics, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such diagnostic, medical and/or office based surgical treatment under the general and specific instructions of the Office of Dr. Samuel A. Taylor.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result or treatments or examinations by the physicians and health care providers of the Office of Dr. Samuel A. Taylor, M.D.

This form will be in effect from this day forward unless I sign a revocation.

Patient Signature: _____ Date: _____.

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INSURANCE/FINANCIAL POLICY

Thank you for choosing Dr. Samuel A. Taylor as your healthcare provider. Our office is committed to providing the highest quality care to all of our patients. We feel it is important to establish a clear insurance/payment policy to avoid misunderstandings. The following information will help you better understand our financial policy:

Patients Enrolled in Participating Health Plans:

- You as the patient will be responsible for all applicable co-payments, co-insurance and deductibles that your plan requires to fulfill payment responsibility. Please make sure you have your insurance card at every visit and if at any time your insurance changes please provide our office with the new insurance information
- If your insurance requires a referral from your primary care physician, it is your responsibility to provide our office with that referral. If a referral is not provided, payment is due at the time services are rendered
- If your insurance carrier is billed and you are reimbursed directly, you are responsible for endorsing and forwarding all payments to Dr. Samuel A. Taylor's office

Patients with Non-Participating Plans:

- Full payment is due at the time of service

Work Related or Motor Vehicle Injury:

- You are responsible for providing all pertinent information regarding your accident and billing information with you. Information such as your insurance claim number, date of injury, description and location of injury as well as guarantors mailing address and telephone number. In you are unable to provide the necessary information; payment in full must be made at the time services are rendered.

I have read and agree to the above insurance/financial policy:

Print Name: _____

Patient Signature: _____ **Date**: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at Hospital for Special Surgery. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protectthe privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Hospital and its medical staff and affiliated health care providers when providing health care services for our Hospital. Our Notice will be posted in the main entrance area of the Hospital at 535 East 70th Street, New York, New York and in other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu, calling Health Information Management at (212) 606-1254, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by the Hospital, and how I may obtain access to and control this information. I also acknowledge and understand special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and/or disclosure of my health information as described in this Notice, including to treat me and arrange for my medical care, to seek and receive payment for services given me, and for the business operations of the Hospital and its staff.

Signature of Patient or Personal Representative _____

Print Name of Patient or Personal Representative _____
Description of Personal Representative's Authority _____
Date: _____

If you have any questions about this Notice or would like further information, please contact the Privacy Officer at (212) 774-7500.

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement.

_____
_____
_____