IMS Shoulder and Knee Care New Patient Registration Form

Patient First Name: ____________________ Middle ________________ Last ________________________________

DOB: __________________ Social Security #: _________________ Email Address: ___________________________

Address: ____
Street City State Zip

Home Phone______________________Cell Phone______________________

Gender ❏ Male ❏ Female ❏ Transgender

Language ❏ English ❏ Spanish ❏ Other ________

Race/Ethnicity ❏ White ❏ Black/African American ❏ Hispanic/Latino ❏ American Indian/Alaska Native
❏ Asian ❏ Native Hawaiian or Other Pacific Islander ❏ Other ___________________________

How did you get referred? ❏ Physician ❏ Friend/Relative ❏ Insurance ❏ Internet

Referring Physician: ____

Primary Care Physician ❏ Same as Referring Physician ____

Employer Name: ____ Work Phone______________________

Address: ____
Street City State Zip

Primary Card Holder Name ❏ Self ____

Relationship to Patient ❏ Self ❏ Spouse ❏ Parent ❏ Child ❏ Other ______________________________________

Insurance Name ____

Policy #__________________________ Group #: ________________________

Secondary Card Holder Name ❏ Self ____

Relationship to Patient ❏ Self ❏ Spouse ❏ Parent ❏ Child ❏ Other ______________________________________

Insurance Name ____

Policy #__________________________ Group #: ________________________

I hereby authorize IMS to release any information required in the course of my examination or treatment to my insurance(s). I also hereby authorize payment directly to IMS for the surgical and/or medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by my insurance. Further, I understand that I am responsible for all charges incurred in the collection of my account(s) and will pay all fees involved should my account(s) placed with a collection service. Finance charges will begin to accrue on any unpaid responsibility balance after 90 days old.

____

Patient/Guardian Signature Date

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for INTEGRATED MEDICAL SERVICES INC**

Signed____ **Date:**____________________

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed____ **Date:**____________________

- **I authorize INTEGRATED MEDICAL SERVICES INC to release medical information required to process my claim**

Signed____ **Date:**____________________

- **I have read and understand the Financial Policy for INTEGRATED MEDICAL SERVICES INC**

Signed____ **Date:**____________________

- **I authorize INTEGRATED MEDICAL SERVICES INC to obtain/have access to my medication history**

Signed____ **Date:**____________________

- **I authorize my provider's office to contact me by mobile phone**

Signed____ **Date:**____________________

Patient Financial Responsibility Agreement

Patient Name: ___________________________ Date of Birth: _______________ Acct #: _______________________

We at Integrated Medical Services, Inc. {"IMS") are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments and Coinsurance: If you have not met your health plan's deductible on the date of service, we will collect an estimated amount before you are seen towards your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments and co-insurance required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: We will do our best to verify coverage before you are seen, but it is ultimately your responsibility to ensure payment of your bill. Any service performed by our providers that is not covered by your insurance is your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Referrals: We will do our best to ensure we have a valid referral for services on file. However, if your insurance policy requires a referral, you are responsible for making sure there is a current and valid referral on file prior to being seen.

Self-Pay: If you don't have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. There may be additional charges depending on the services actually provided for which you may receive a bill.

Returned Checks: We charge a $25.00 fee for any returned checks.

No Show Policy: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before they are to be seen in our office. Failure to cancel an appointment in a timely manner will result in a No Show fee of $25.00. Multiple No Shows may result in the patient being discharged from IMS.

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees and finance charges may be added to unpaid delinquent accounts. Finance fees of $5 will accrue each time a new statement is generated after the first statement was sent out and partial or no payment have been made. Your account may be sent to a collection agency if the balance is 90 days old and partial or no payment has been made towards the balance.

Contact: If you have any questions regarding your bill, please contact the IMS billing office at **(602) 633-3838.**

I have read the above financial policies of IMS and agree to be bound by its terms. I also understand that IMS has the right to amend these policies at any time.

Signature of Patient or Responsible Party: ___________________________________ Date: ___________________

Printed Name of Patient: ____

Printed Name of Responsible Party: _________________________________ Relation to Patient: ______________________

Contact Phone Number of Responsible Party: ____

Integrated Medical Services, Inc.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Integrated Medical Services, Inc. ("IMS") is committed to protecting the confidentiality of its patients' health information. This Notice of Privacy Practices describes how we may use and disclose your health information and the rights that you have regarding your health information.

HOW WILL WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use or disclose your health information without your authorization for the following purposes:

Treatment: We will use and disclose your health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we may disclose your health information, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your health information will be used or disclosed, as needed, to obtain payment for your health care services. For example, we may bill your health plan for the cost of the services we provide to you. We may also contact your health plan to determine whether it will authorize payment for services, to determine the amount of your co-payment or to obtain approval for a hospital admission.

Healthcare Operations: We may use or disclose your health information, as needed, in order to support the business activities of your physician's practice. These activities include, but are not limited to, training and education, quality assessment activities, risk management, claims management, legal consultation, physician and employee review activities, licensing, regulatory surveys, and other business planning activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

Appointments and Health-Related Services: We may use your health information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. If you do not want us to disclose your medical information to family members or others involved in your care, please contact our Privacy Officer.

Business Associates: We enter into contracts with third-party entities known as business associates. These business associates provide services to or perform functions on our behalf, such as our accountants, consultants and attorneys. We may disclose your relevant health information to our business associates once they have agreed in writing to safeguard your medical information. Business associates are also required by law to protect the privacy of your health information.

Required by Law: We will disclose your health information when we are required to do so by federal, state or local law.

Public Health Activities: We may use your health information for public health activities such as reporting births, deaths, communicable diseases, injuries, or disabilities and ensuring the safety of drugs and medical devices.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities such as audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.

Food and Drug Administration (FDA): We may disclose your health information to a person or company subject to the FDA to report adverse events, product defects or problems or biologic product deviations; to track FDA-regulated products; to enable product recalls; to make repairs or replacements; to conduct post-marketing surveillance information or for other purposes related to the quality, safety or effectiveness of a product or activity regulated by the FDA.

Law Enforcement: We may disclose your health information to law enforcement in limited circumstances, such as to identify or locate suspects, fugitives, witnesses or victims of a crime, to report deaths from a crime, to report crime on our premises or in emergency treatment situations.

Judicial and Administrative Proceedings: We may disclose information about you in response to an order of a court or administrative tribunal as expressly authorized by such order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process not accompanied by an order of a court or administrative tribunal, under certain circumstances as permitted by law.

To Avert a Serious Threat to Health or Safety: We may use or disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We may also disclose information about you if it is necessary for law enforcement authorities to identify or apprehend an individual.

Disaster Relief Efforts: We may use or disclose your health information to an authorized public or private entity to assist in disaster relief efforts. You may have the opportunity to object unless it would impede our ability to respond to emergency circumstances.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information consistent with applicable law to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose health information consistent with applicable law to organizations that handle organ, eye or tissue donation or transplantation.

Fundraising: We may use certain information to contact you as part of our fundraising efforts. If you receive such a communication from us, you will be provided an opportunity to opt-out of receiving such communications in the future.

Workers' Compensation: We may disclose your health information as authorized to comply with workers' compensation laws and other similar programs established by law.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your health information as required by military command authorities or to the Department of Veterans Affairs. We may also disclose medical information to authorized federal officials for intelligence and national security purposes.

Correctional Institutions: If you are or become an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose to the institution or law enforcement official information necessary for the provision of health services to you, your health and safety, the health and safety of other individuals and law enforcement on the premises of the institution and the administration and maintenance of the safety, security and good order of the institution.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

Research: Under certain circumstances, we may also use and disclose information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information and balances the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. However, we may disclose your PHI to people preparing to conduct a research project, so long as the PHI they review is not removed from us. We may also use or disclose your PHI to contact you (or, under certain circumstances, to allow a research entity with whom we contract to contact you) about the possibility of enrolling in a research study.

If you do not want to be contacted about the possibility of enrolling in a research study (as described above), please initial here: ________________

Other Uses and Disclosures: If we wish to use or disclose your health information for a purpose not discussed in this Notice, we will seek your authorization. Specific examples of uses and disclosures of your health information requiring your authorization include: (i) most uses and disclosures of psychotherapy notes (private notes of a mental health professional kept separately from

a medical record); (ii) most uses and disclosures of your health information for marketing purposes; and (iii) disclosures of your health information that constitute the sale of your health information. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

YOUR HEALTH INFORMATION RIGHTS

Although your health information is our property, you have the right to:

Request access to your health information. You may request to inspect and/or obtain a copy of your health information. If we maintain your health information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. If you request a copy (paper or electronic), we may charge you a reasonable, cost-based fee. Any request to access your health information must be in writing and submitted to our Privacy Officer.

Request a restriction on the use or disclosure of your health information. You may ask us not to use or disclose any part of your health information for a particular reason related to treatment, payment or health care operations. We will consider your request, but we are not legally obligated to agree to a requested restriction except for in the following situation: If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We are required to abide by such a request, except where we are required by law to make the disclosure. Any request for a restriction must in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request to receive confidential communications. You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request an amendment to your medical information. If you believe that any information in your medical record is incorrect, or if you believe important information is missing, you may request that we correct the existing information or add the missing information. Such a request must be in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request an accounting of certain disclosures. You have the right to request a list of certain disclosures we have made of your health information. Any request for an accounting must be in writing and submitted to our Privacy Officer. The first list in any 12-month period will be provided to you for free, but you may be charged for any additional lists requested during the same 12-month period.

Receive a paper copy of this Notice. You have the right to receive a paper copy of this Notice upon request, even if you agreed to accept this Notice electronically.

OUR RESPONSIBILITIES

We are required to (i) maintain the privacy of your health information as required by law; (ii) provide you with notice of our legal duties and privacy practices with respect to your health information, and to abide by the terms of such notice; and (iii) notify you following a breach of your health information that is not secured in accordance with certain security standards.

We reserve the right to change the terms of this Notice and to make the provisions of the new Notice effective for all health information that we maintain. If we change the terms of this Notice, the revised Notice will be made available upon request and posted in our practice locations. Copies of the current Notice may be obtained by contacting our Privacy Officer.

Health Information Exchange (HIE)

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

QUESTIONS, CONCERNS OR COMPLAINTS

If you have any questions or want more information about this Notice or how to exercise your privacy rights, please contact our Privacy Officer at 1-888-787-9845 or by mail at 9250 N. 3rd Street, Suite 4010, Phoenix, Arizona 85020

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with us, you may contact our Privacy Officer. To file a complaint with HHS, you may contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 (OCRComplaint@hhs.gov). **We will not retaliate against you for filing a complaint.**

Effective Date: September 23, 2013

Signature below is acknowledgment that you have read and understand this Notice.

Patient Name: ______________________________ DOB: _________________________________

Signature: _________________________________ Date: _________________________________

RELEASE OF INFORMATION

I _______________________________________ hereby authorize IMS to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: ___________________________________ Relationship:___________________________ Phone Number____

Name: ___________________________________ Relationship:___________________________ Phone Number____

Name: ___________________________________ Relationship:___________________________ Phone Number ____

I authorize IMS to contact me at:

Home Phone _____________________________________Work Phone ___________________

May we leave a message on machine? __ Yes __ No

Cell Phone ______________________________________Alternate Phone _________________

Patient Signature_______________________ **Date ________________________**

Witness:________________________________ Date ________________________

IMS SHOULDER AND KNEE CARE OFFICE POLICY

Follow-up appointments: All patients are responsible for making their follow-up appointments and must arrive on time. Any patient that arrives after their scheduled appointment time may be asked to reschedule at the discretion of the provider.

No show appointments: Should a patient cancel and/or no show three visits within a 12-month period, IMS SHOULDER & KNEE reserves the right to discontinue the provider-patient relationship. A letter will be sent to the patient to notify of such.

Missed appointments: There is a $25.00 charge for each missed appointment. This fee is billed directly to you and will NOT be paid by your insurance. If you decide to schedule another appointment, all missed appointment charges must be collected in full prior to being seen by the Doctor.

Medical records copies: Should the patient need a copy of their medical records for personal use or continuity of care; please contact the medical records department. (Release of information form will be required). Charges may apply.

Disability/FMLA/ insurance paperwork: There is a $25.00 fee for any paperwork that is to be completed by your orthopedic physician; this includes but is not limited to FMLA paperwork, disability paperwork, and physical capacity statements. Payment is required prior to completion.

Medical/legal attorney: Paperwork and forms requested through your attorney has a separate fee schedule. Please ask for a rate schedule.

Pets: No pets are allowed. Appropriately identified service animals are acceptable.

Other treatment agencies: In compliance with the requirements of this law . A.R.S. §32-1401(27)(ff), you are being advised Dr. Weng has a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services Dr. Weng has prescribed are available elsewhere on a competitive basis. Dr. Weng does have a financial interest in a separate treatment agency Desert Ridge Outpatient Surgery Center.

Messages: Should a patient leave a message with our office or through the answering service, they can anticipate a return call by the next business day and not the day of. If you deem this to be an emergency then you should dial 911 or go to the emergency room.

Narcotic policy: **No narcotics are prescribed unless you have had surgery by Dr. Weng and are with in the "global period."** No pain medications or routine medications will be called in after hours. Patients will have to wait until the next business day to discuss with their provider. Narcotic refills requests are done in writing, through the patient portal. Request in advance for medication refills.

Expected Standards of Behavior: IMS Shoulder and Knee Care has a duty to provide a safe and secure environment for staff, patients and visitors. Please note that this medical practice operates a "Zero Tolerance" policy and any patients who commit against any staff member or other patients, either in person or by phone, or behaves in such a way that any such person fears for their safety, the patient's treatment will be terminated. The following are examples of unacceptable behavior on practice premises: violence, excessive noise, shouting, threatening, abusive language involving swearing or offensive remarks, malicious allegations relating to members of staff, other patients or visitors, taking alcohol, smoking, illicit drug use or dealing while on practice premises, willful damage to practice property, offensive dress or body odors., etc. This list is not exhaustive. If deemed appropriate, the police may be called.

I have read the IMS SHOULDER & KNEE, office policy. I will have a copy only if I asked for one. I agree to follow this policy at all times.

Patient/Guarantor Signature:____Date: ____________________

IMS Shoulder and Knee Care Patient History

Michael S Weng, MD

Dear Patient,

Thank you for completing the following Patient History form. The information you provide will allow us to give you the best care possible, so please fill it as completely and accurately as you can.

I do apologize for the length of the form. I have tried to make it as "check list" as possible to minimize your writing.

Please note that many of the questions asked are required through various health regulations and rules we as healthcare providers are obligated to follow.

If you wish to elaborate on any question or provide additional comment, please write in the borders of this form or ask for additional paper.

I, patient, certify that the following information is true and to the best of my ability.

____ Date ______________

Patient's/Guardian's Signature

____

Please Print Patient's Name

Your Primary Care Provider (PCP) ______________________________

How were you referred?: ❑ PCP ❑ Friend/Relative ❑ Insurance ❑ Online

Birthdate ______________ **Your Age** __________

Preferred Pharmacy Information

Pharmacy: ____________________ Phone #: ____________ Fax #: __________

Address: ______________________________ City/State/Zip: ________________

Office use only

I have reviewed the following patient provided information:

____

Michael S Weng, MD

Room _____

Height ________ Weight _______ BP __________ Pulse __________

IMS SHOULDER AND KNEE CARE MICHAEL S WENG MD

IMS Shoulder and Knee Care Patient History

History of Present Illness

Location of Problem ❑ Right Shoulder ❑ Left Shoulder ❑ Right Knee ❑ Left Knee ❑ Other ________

How did your problem begin? ____

____

How long have you had your problem? ____

Did the problem result from a specific injury? ❑ No Injury ❑ Yes Injury/Accident Date: ________

If injured, was the injury due to a: ❑ Fall ❑ Strike ❑ Work Injury ❑ Car Accident ❑ Sports Injury

Quality of Pain/Is the pain:

❑ None ❑ Sharp ❑ Dull ❑ Throbbing ❑ Stabbing ❑ Burning ❑ Other ____________

Severity Please rate your pain on a scale of 0 to 10 (10 being the most painful):

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Timing of Problem/Pain ❑ Constant ❑ With lifting ❑ With overhead activity

❑ With exercise ❑ Night pain ❑ Stair climbing ❑ Walking

❑ Other ____

Context Are you? ❑ Improving ❑ Getting Worse ❑ Staying the same

Modifying Factors:

What, if anything makes your symptoms better? ________________________________

What, if anything makes your symptoms worse? ________________________________

What associated musculoskeletal/neurological symptoms are you experiencing? ❑ None

❑ Swelling ❑ Locking ❑ Catching ❑ Giving way ❑ Popping ❑ Grinding

❑ Stiffness ❑ Weakness ❑ Instability ❑ Tingling ❑ Numbness ❑ Unsteady gait

❑ Other ____

Have you seen another healthcare provider for this problem? ❑ No ❑ Yes who ____________

What treatments have you tried? (Check all that apply)

❑ None ❑ Home Exercise ❑ Physical Therapy

❑ Naturopathic /Herbs ❑ Chiropractic Manipulation ❑ Acupuncture

Medicines: ❑ NSAID's (Motrin, ibuprofen, Aleve etc) ❑ Narcotics (Percocet etc)

Injections: ❑ Cortisone/steroid ❑ Gel/Rooster comb shots (Orthovisc, Synvisc, Supartz,etc)

Surgery: ❑ Arthroscopy ❑Joint Replacement ❑ Fracture fixation

Other Treatments ____

Have you had other tests for your problem?

❑ None ❑ X Rays ❑ MRI ❑ CT Scan ❑ EMG/NCV ❑ Blood Work

If so, where? ____

IMS SHOULDER AND KNEE CARE MICHAEL S WENG MD

IMS Shoulder and Knee Care Patient History

Review of Systems/ Other Symptoms (past 12 months)

❑ All None in past 12 months.

CONSTITUTIONAL	❑ None	❑ Fever	❑ Chills		
EYES	❑ None	❑ Glasses/Contacts		❑ Blurred/double Vision	
EAR, NOSE, THROAT	❑ None	❑ Cavities	❑ Nosebleeds		
HEART	❑ None	❑ Chest Pain	❑ Murmurs	❑ Leg Claudication	
RESPIRATORY	❑ None	❑ Cough	❑ Wheezing	❑ Shortness of Breath	
GASTROINTESTINAL	❑ None	❑ Heartburn	❑ Nausea	❑ Constipation	❑ Diarrhea
GENITOURINARY	❑ None	❑ Difficult/painful urination		❑ Incontinence	
		❑ Irregular Periods		❑ Abnormal Vaginal Bleeding	
SKIN	❑ None	❑ Itching	❑ Rash	❑ Poor healing skin	
PSYCHIATRIC	❑ None	❑ Anxiety	❑ Depression		
HEMATOLOGY	❑ None	❑ Easy Bleeding		❑ Easy Bruising	
ENDOCRINE	❑ None	❑ Excessive thirst/urination		❑ Heat/cold Intolerance	

WOMEN ONLY: Are you pregnant? ❑ No ❑ Yes Please also inform the staff verbally

Allergies/Drug Reactions

❑ No known drug allergies

	Anaphy-laxis	Trouble Breathing	Rash	Swelling	Stomach	Constipation	Other/List
Penicillin	❑	❑	❑	❑	❑	❑	
Sulfa	❑	❑	❑	❑	❑	❑	
IV dye	❑	❑	❑	❑	❑	❑	
NSAIDS/ASA	❑	❑	❑	❑	❑	❑	
Narcotics	❑	❑	❑	❑	❑	❑	
Latex	❑	❑	❑	❑	❑	❑	

❑ No known food allergies

Shellfish	❑	❑	❑	❑	❑	❑	
Egg/Poultry	❑	❑	❑	❑	❑	❑	
Peanut	❑	❑	❑	❑	❑	❑	

Please list all other allergies and reactions: ____

If you have had an allergy to PCN and Sulfa, please list antibiotics you can take:____________________

IMS SHOULDER AND KNEE CARE MICHAEL S WENG MD

IMS Shoulder and Knee Care Patient History

Past Medical History/Problems Please check current or previous medical conditions

- ❑ No previous/current medical problems
- ❑ Diabetes Type 1 (insulin Dependent) ❑ Diabetes Type 2 (No insulin)
- ❑ DVT/Blood Clots ❑ Pulmonary Embolus ❑ Anemia ❑ Asthma /COPD ❑ Prostate
- ❑ Heart Disease ❑ Thyroid ❑ High Blood Pressure ❑ Kidney Disease
- ❑ Hepatitis B or C ❑ HIV ❑ Poor Circulation ❑ Strokes/Seizures
- ❑ Sleep Apnea ❑ Rheumatoid arthritis ❑ Liver Disease ❑ Hyperlipidemia
- ❑ Cancer/Other (list) ______________________________

Are you on any Blood thinners? ❑ No ❑ Yes (list what you take in medicine section)

Are you in Pain management? ❑ No ❑ Yes (list what you take in medicine section)

If you are in Pain Management, name of your doctor: ______________________________

Past Surgical History/Problems Please check current or previous surgical conditions

- ❑ No previous/current surgeries
- ❑ Appendectomy ❑ Hernia Repair ❑ Gallbladder ❑ Tonsils
- ❑ Spine Surgery ❑ Total Joint Replacement ❑ C Section ❑ Breast
- ❑ Heart Surgery ❑ Vascular/endarterectomy ❑ Hysterectomy
- ❑ Prostate ❑ D and C
- ❑ Other/Other (list) ______________________________
- ❑ Anesthesia Issues ______________________________

Family History Please check family history conditions

❑ All negative ❑ Unknown

	Father	Mother	Brother	Sister	Children
❑ Anesthesia Issues	❑	❑	❑	❑	❑
❑ Bleeding Disorder	❑	❑	❑	❑	❑
❑ Diabetes	❑	❑	❑	❑	❑
❑ Heart Disease	❑	❑	❑	❑	❑
❑ Kidney Disease	❑	❑	❑	❑	❑
❑ Other ____________	❑	❑	❑	❑	❑

IMS SHOULDER AND KNEE CARE MICHAEL S WENG MD

IMS Shoulder and Knee Care Patient History

Medications ❑ See attached list

Prescription Medication	Dosage	Frequency
________	________	________
________	________	________
________	________	________
________	________	________

Over the Counter Medication	Dosage	Frequency
________	________	________
________	________	________

Herbs/Vitamins	Dosage	Frequency
________	________	________
________	________	________

Street/Illegal Drug Use: if used in past year: ❑ None ❑ Marijuana ❑ Narcotics ❑ IV Drugs ❑ Other

Social History

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Committed Relationship

Hand Dominance ❑ Left ❑ Right ❑ Ambidextrous

Occupation ❑ Currently Working ❑ Retired ❑ Unemployed ❑ Disabled

What type of work do you do now or in the past (job title): ________________

Alcohol Use

❑ Never alcohol ❑ How much ________________

Smoking

❑ Never smoker

❑ Former smoker When did you quit? ________

❑ Cigarette smoker How much per day________

❑ Vape How much per day________

❑ Cigars/Pipe How much per day________

❑ Chew tobacco How much per day________

❑ Marijuana How much per day________

❑ Yes Marijuana Card (Please provide card so we can make a copy)

IMS SHOULDER AND KNEE CARE MICHAEL S WENG MD