



**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

FONDREN ORTHOPEDIC GROUP L.L.P.

I, [name of patient] \_\_\_\_\_, acknowledge and agree that I have reviewed a copy of **Fondren Orthopedic Group's Notice of Privacy Practices**.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient's Legal Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Representative

\_\_\_\_\_  
Relationship to patient

**Clinic Use Only:**

**Fondren Orthopedic Group, LLP** made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Employee

\_\_\_\_\_  
Title

**Fondren Orthopedic Group, L.L.P.**

7401 South Main Street  
Houston, TX 77030-4509  
713-799-2300

**Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor**

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.**, your medical provider, to: (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from the redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

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**Print Patient's Name**

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**Patient's Signature**

---

**Date**

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

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**Print Legal Representative's Name**

---

**Legal Representative's Signature**

---

**Date**

# PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

AFFECTED SIDE? R or L DESCRIBE PROBLEM: \_\_\_\_\_

**PAST MEDICAL HISTORY (CHECK ANY THAT APPLY TO YOU) \_\_\_\_\_ NONE APPLY**

<input type="checkbox"/> ANEMIA	<input type="checkbox"/> CA LUNG	<input type="checkbox"/> HEART STENT	<input type="checkbox"/> NEUROLOGICAL DISORDER
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> CA OVARIAN	<input type="checkbox"/> HEPATITIS A B C	<input type="checkbox"/> NUMBNESS/TINGLING
<input type="checkbox"/> ASBESTOSIS	<input type="checkbox"/> CA PROSTATE	<input type="checkbox"/> IRREGULAR HEARTBEAT	<input type="checkbox"/> OSTEOARTHRITIS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> CA THYROID	<input type="checkbox"/> HIATAL HERNIA	<input type="checkbox"/> PNEUMONIA
<input type="checkbox"/> BIPOLAR DISORDER	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> POOR CIRCULATION
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> CHRONIC BACK PAIN	<input type="checkbox"/> HIV	<input type="checkbox"/> PULMONARY EMBOLISM
<input type="checkbox"/> BLOOD CLOT	<input type="checkbox"/> COR. ARTERY DISEASE	<input type="checkbox"/> HYPERTHYROIDISM	<input type="checkbox"/> REFLUX
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> CON. HEART FAILURE	<input type="checkbox"/> HYPOTHYROIDISM	<input type="checkbox"/> RHEUMATOID ARTHRITIS
<input type="checkbox"/> CANCER	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> SEIZURE
<input type="checkbox"/> CA BRAIN	<input type="checkbox"/> DIABETES	<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> SLEEP APNEA
<input type="checkbox"/> CA BREAST	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> LUNG PROBLEMS	<input type="checkbox"/> STROKE
<input type="checkbox"/> CA CERVICAL	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> LUPUS	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> CA COLON	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> MIGRAINES	<input type="checkbox"/> UTI
<input type="checkbox"/> CA KIDNEY	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> OTHER _____	

**PAST SURGICAL HISTORY (CHECK ANY THAT APPLY TO YOU) \_\_\_\_\_ NONE APPLY**

<input type="checkbox"/> ABDOMINAL SURGERY	<input type="checkbox"/> GALLBLADDER REMOVAL	<input type="checkbox"/> PARATHYROIDECTOMY
<input type="checkbox"/> AMPUTATION	<input type="checkbox"/> GASTRIC BYPASS/BANDING	<input type="checkbox"/> PNEUMONECTOMY
<input type="checkbox"/> ANGIOPLASTY	<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> PROSTATECTOMY
<input type="checkbox"/> APPENDECTOMY	<input type="checkbox"/> HEMORRHOIDECTOMY	<input type="checkbox"/> ROTATOR CUFF REPAIR
<input type="checkbox"/> ARTHROSCOPY KNEE	<input type="checkbox"/> HIP REPLACEMENT	<input type="checkbox"/> SPINE SURGERY CERVICAL
<input type="checkbox"/> ARTHROSCOPY SHOULDER	<input type="checkbox"/> HYSTERECTOMY COMPLETE	<input type="checkbox"/> SPINE SURGERY THORACIC
<input type="checkbox"/> BRONCHOSCOPY	<input type="checkbox"/> HYSTERECTOMY PARTIAL	<input type="checkbox"/> SPINE SURGERY LUMBAR
<input type="checkbox"/> CABG	<input type="checkbox"/> INTERVENTIONAL PAIN PROCEDURES	<input type="checkbox"/> TONSILLECTOMY
<input type="checkbox"/> CAROTID ENDARTERECTOMY	<input type="checkbox"/> KNEE REPLACEMENT	<input type="checkbox"/> TURP
<input type="checkbox"/> COLON RESECTION	<input type="checkbox"/> KYPHOPLASTY	<input type="checkbox"/> VASECTOMY
<input type="checkbox"/> FEMORAL BYPASS	<input type="checkbox"/> NEPHRECTOMY	<input type="checkbox"/> VERTEBROPLASTY
<input type="checkbox"/> FRACTURE REPAIR	<input type="checkbox"/> PACEMAKER	<input type="checkbox"/> OTHER _____

**FAMILY HISTORY (CHECK ANY THAT APPLY) \_\_\_\_\_ NONE APPLY**

<input type="checkbox"/> ANESTHESIA PROBLEMS	<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIABETES
<input type="checkbox"/> OSTEOPOROSIS	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HYPERTENSION (MOM)	<input type="checkbox"/> HYPERTENSION (DAD)
<input type="checkbox"/> STROKE	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> CANCER	<input type="checkbox"/> CA BREAST
<input type="checkbox"/> CA CERVICAL	<input type="checkbox"/> CA COLON/RECTAL	<input type="checkbox"/> CA BRAIN	<input type="checkbox"/> CA LUNG
<input type="checkbox"/> CA OVARIAN	<input type="checkbox"/> CA PROSTATE	<input type="checkbox"/> CA KIDNEY	<input type="checkbox"/> CA THYROID
<input type="checkbox"/> OTHER _____			

**SOCIAL HISTORY (CHECK ALL THAT APPLY TO YOU) \_\_\_\_\_ NONE APPLY**

<input type="checkbox"/> SINGLE	<input type="checkbox"/> CIGARETTE SMOKING	<input type="checkbox"/> PHYSICAL WORK	<input type="checkbox"/> STUDENT
<input type="checkbox"/> MARRIED	<input type="checkbox"/> PIPE SMOKING	<input type="checkbox"/> SEDENTARY WORK	<input type="checkbox"/> REGULAR DUTY
<input type="checkbox"/> DIVORCED	<input type="checkbox"/> CHEWING TOBACCO	<input type="checkbox"/> RETIRED	<input type="checkbox"/> LIGHT DUTY
<input type="checkbox"/> WIDOWED	<input type="checkbox"/> ALCOHOL	<input type="checkbox"/> HOMEMAKER	<input type="checkbox"/> OUT OF WORK

**MEDICATIONS TAKEN DAILY (NAME AND DOSAGE) \_\_\_\_\_ NONE**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHARMACY USED:** \_\_\_\_\_ **PH#** \_\_\_\_\_

**ALLERGIES TO MEDICINE: (LIST ALL) \_\_\_\_\_ NO ALLERGIES**

\_\_\_\_\_  
\_\_\_\_\_

**WAS THIS RELATED TO AN AUTOMOBILE ACCIDENT? \_\_\_\_\_ Y \_\_\_\_\_ N**

# REVIEW OF SYSTEMS

(Please circle YES or NO if any currently apply to you)

PRINT PATIENT NAME: \_\_\_\_\_ PATIENT DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

Have you had any new symptoms? Yes No Do you have diabetes? Yes No

## GENERAL:

Fever? Yes No  
Chills? Yes No  
Sweats? Yes No  
Weakness? Yes No  
Malaise?(discomfort) Yes No  
Abnormal Weight Loss? Yes No  
Sleep Disturbance? Yes No

## SKIN:

Sensation Disturbance? Yes No  
Bruising? Yes No  
Birthmark? Yes No  
Rash? Yes No  
Itching? Yes No  
Dryness? Yes No  
Suspicious Lesions? Yes No

## EYES, EARS, NOSE, THROAT:

Double Vision? Yes No  
Blurred Vision? Yes No  
Eye Irritation? Yes No  
Eye Discharge? Yes No  
Vision Loss? Yes No  
Eye Pain? Yes No  
Light Sensitivity? Yes No  
Earache? Yes No  
Ringing in Ears? Yes No  
Nasal Congestion? Yes No  
Nosebleeds? Yes No  
Sore Throat? Yes No  
Difficulty Swallowing? Yes No  
Hearing Loss? Yes No

## NEUROLOGICAL:

Headaches? Yes No  
Memory Loss? Yes No  
Confusion? Yes No  
Transient Paralysis? Yes No  
Weakness? Yes No  
Numbness? Yes No  
Tingling? Yes No  
History of Seizures? Yes No  
Syncope?(fainting) Yes No  
Tremors? Yes No  
Vertigo?(dizzy) Yes No

## CARDIAC:

Chest Discomfort? Yes No  
Chest Pains? Yes No  
Palpitations? Yes No  
Syncope?(fainting) Yes No  
Shortness of Breath? Yes No  
Numbness in Arms? Yes No  
Swelling of Limbs? Yes No

## PSYCHIATRIC:

Depression? Yes No  
Anxiety? Yes No  
Memory Loss? Yes No  
Mental Disturbance? Yes No  
Suicidal Thoughts? Yes No  
Mood Disorders? Yes No  
Paranoia? Yes No  
Sleep Disturbances? Yes No  
Eating Disorder? Yes No

## RESPIRATORY:

Cough? Yes No  
Shortness of Breath? Yes No  
Wheezing? Yes No  
Chest Congestion? Yes No

## ENDOCRINE:

Sensitivity to Cold? Yes No  
Sensitivity to Heat? Yes No  
Abnormal Weight Gain? Yes No  
Excessive Thirst? Yes No  
Excessive Urination? Yes No  
Excessive Hunger? Yes No  
Diabetes? Yes No

## GASTROINTESTINAL:

Nausea? Yes No  
Vomiting? Yes No  
Diarrhea? Yes No  
Constipation? Yes No  
Abdominal Pain? Yes No  
Blood in Stool? Yes No  
Heartburn? Yes No

## HEMATOLOGIC / LYMPHATIC:

Chronic Infections? Yes No  
Abnormal Bruising? Yes No  
Bleeding? Yes No  
Enlarged Lymph Nodes? Yes No

## GENITOURINARY:

Painful Urination? Yes No  
Blood in Urine? Yes No  
Urinary Frequency? Yes No  
Urinary Hesitancy? Yes No  
Incontinence? Yes No

## ALLERGIC / IMMUNOLOGIC:

Hives? Yes No  
Hay Fever? Yes No  
Persistent Infections? Yes No  
HIV Exposure? Yes No  
Runny Nose? Yes No  
Sinus Congestion? Yes No

## MUSCULOSKELETAL:

Back Pain? Yes No  
Joint Pain? Yes No  
Joint Swelling? Yes No  
Muscle Soreness? Yes No  
Arthritis? Yes No

## EXTREMITIES:

Redness of a limb? Yes No  
Swelling of a limb? Yes No  
Discoloration of a limb? Yes No

**NEW PATIENT BACK, NECK AND HIP QUESTIONNAIRE**

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**How long have you had this problem?** \_\_\_\_\_

**Did you have an injury? YES or NO Was this work related? YES or NO**

**Date of injury:** \_\_\_\_\_

**How injury occurred:** \_\_\_\_\_

**Have you seen other physicians for this? YES or NO**

**List names:** \_\_\_\_\_

**What treatment have you had? Please include self treatment. (please circle)**

**NONE**

**Medications (list)** \_\_\_\_\_

**Brace**

**Physical Therapy**

**Home Exercise Program**

**Injections / Shots**

**Have you had any trouble with control of your bladder or bowel? YES or NO**

**Does your pain increase with coughing or sneezing? YES or NO**

**Does your pain increase with:**

**Sitting? YES or NO**

**Standing? YES or NO**

**Laying? YES or NO**

**Have you had any diagnostic testing?**

**X-rays YES or NO**

**MRI YES or NO**

**EMG(nerve studies) YES or NO**

**CT Scan YES or NO**

**Myelogram YES or NO**

**MARK THE AREAS OF YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS: USE THE APPROPRIATE SYMBOL AND INCLUDE ALL THE AREAS, WHICH ARE AFFECTED:**

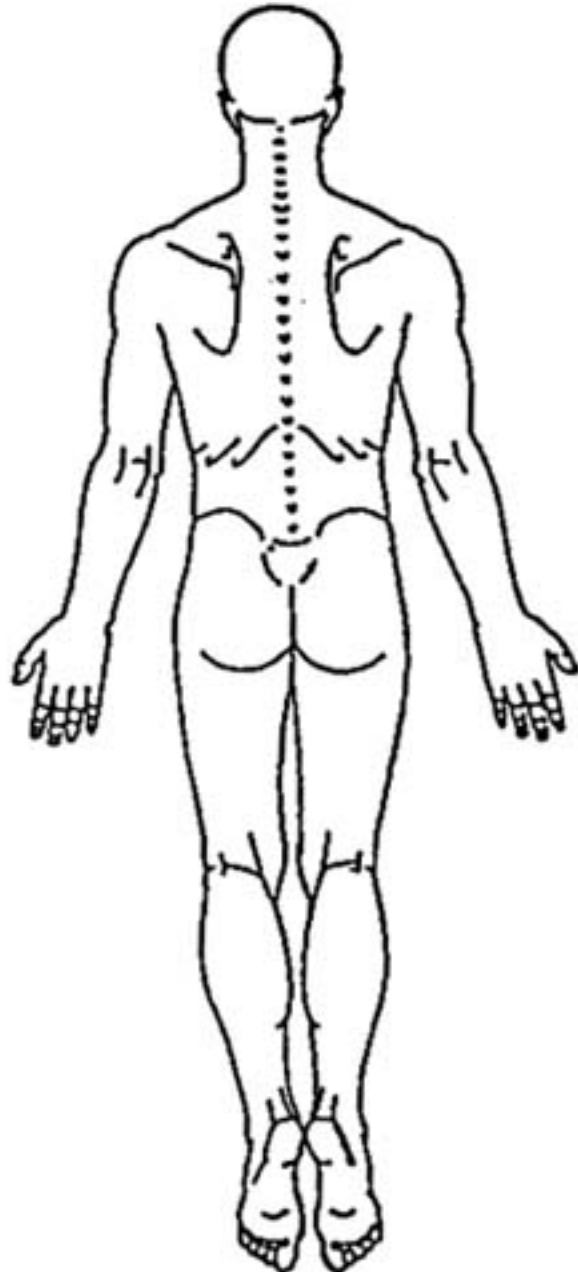
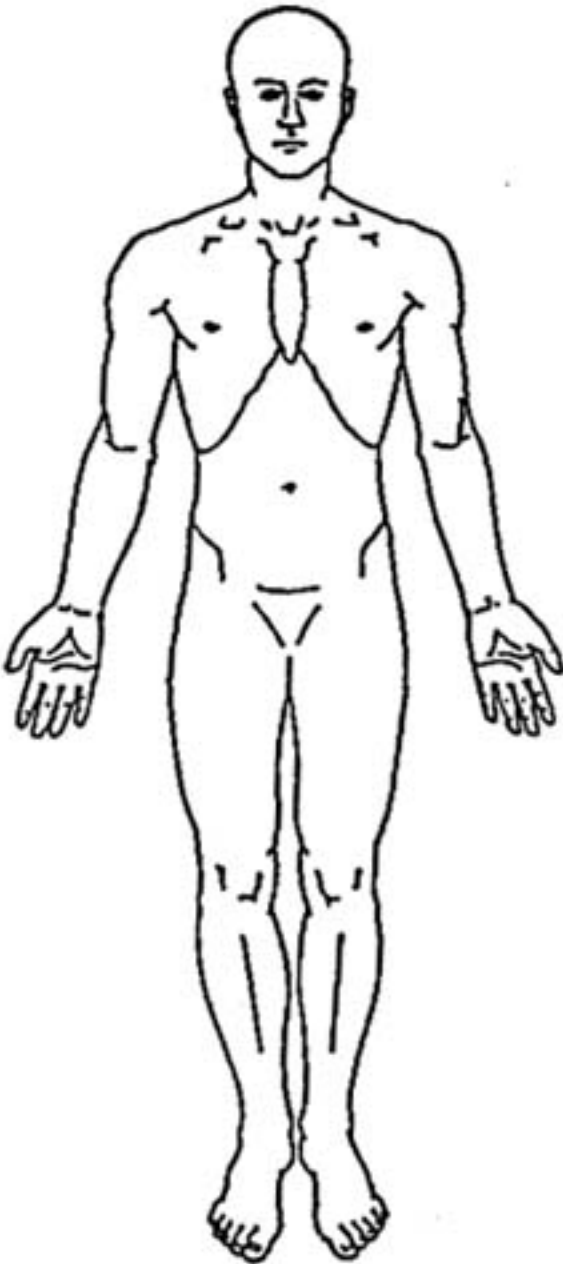
**ACHE**  
++++

**NUMB**  
=====

**PINS/NEEDLES**  
00000000000000

**BURNING**  
XXXXXXXX

**STABBING**  
////////////////////



**NEW PATIENT KNEE QUESTIONNAIRE**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

Please Circle One:

**RIGHT KNEE**

**LEFT KNEE**

**BOTH KNEES**

How long has your knee(s) bothered you? \_\_\_\_\_

Is this an injury?            **YES**        **or**        **NO**

Date of injury: \_\_\_\_\_

How injury occurred: \_\_\_\_\_

Have you seen other physicians for this?            **YES**        **or**        **NO**

(If yes, please list) \_\_\_\_\_

What treatments have you had? Please include self treatment.

**NONE**

**MEDICATIONS (list)** \_\_\_\_\_

**BRACE**

**PHYSICAL THERAPY**

**HOME EXERCISE PROGRAM**

Does your knee:

**Y or N        POP**

**Y or N        CLICK**

**Y or N        SWELL**

**Y or N        GIVE OUT**

**Y or N        CATCH**

**Y or N        GET STIFF AFTER SITTING**

**Y or N        WAKE YOU UP AT NIGHT BECAUSE OF PAIN**

**PLEASE USE GRAPH BELOW TO DEMONSTRATE WHERE YOUR KNEE HURTS**

