DAVID BLOOME,MD
Fondren Orthopedic Group, L.L.P.
Patient History Form **(Please complete to the best of your ability)**

Patient Name: _____ Date of Visit: _____/_____/_____

Date of Birth: ___/___/_____ Age: _____ Height: _____ Weight: _____ Sex: ❑ Male ❑ Female

Referral Source: _____ Date of Injury: _____/_____/_____

Injury Occurred: ❑ Playing a Sport ❑ At Work ❑Motor Vehicle Accident ❑ Other: _____

Chief Complaint: ❑ Right ❑ Left Please Explain: _____

Have you sought prior medical attention for this problem: ❑ NO ❑ YES

If yes, from whom: _____Date: _____ Were X-Rays taken? ❑ NO ❑ YES MRI or CT scan performed? ❑ NO ❑ YES

Are you taking any medications, or vitamins? ❑ (List attached) _____
_____
_____

Are you allergic to any medications? ❑ NO ❑ YES, (Please list) _____

Social History: Do you smoke? _____ Amount? _____ per _____ Drug use? ❑ NO ❑ YES; type: _____

Alcohol use? _____ ❑ Rarely ❑ Socially ❑ Moderate Amount? _____ Per _____

Occupation: _____ ❑ Student ❑Full Duty ❑ Light Duty ❑ Not Working ❑ Retired

Dominance: ❑ Right Hand ❑ Left Hand

Females Only: Are you pregnant? ❑Yes ❑No Date of last menstrual cycle: _____

PAST MEDICAL HISTORY (Please check all that apply to you)

❒NONE APPLY
❒ANEMIA ❒CANCER ❒NEUROLOGICAL DISORDER ❒ANXIETY ❒HEPATITIS A B C (circle one)
❒IRREGULAR HEARTBEAT ❒ASTHMA ❒HIGH CHOLESTEROL ❒POOR CIRCULATION
❒HIV ❒BLOOD CLOT ❒CORONARY ARTERY DISEASE ❒THYROID ❒ REFLUX ❒BRONCHITIS
❒CONGESTIVE HEART FAILURE ❒ RHEUMATOID ARTHRITIS ❒DEPRESSION ❒ SEIZURES ❒DIABETES ❒LIVER PROBLEMS ❒ SLEEP APNEA ❒LUNG PROBLEMS ❒ STROKE ❒HEART ATTACK
❒OTHER_____

PAST SURGICAL HISTORY

❒NONE APPLY
❒GALLBLADDER REMOVAL ❒GASTRIC BYPASS/BANDING ❒ANGIOPLASTY ❒HEART SURGERY
❒APPENDECTOMY ❒HEMORRHOIDECTOMY ❒HYSTERECTOMY ❒ C-SECTION
❒OTHER_____

FAMILY HISTORY

❒NONE APPLY
❒ ANESTHESIA PROBLEMS ❒BLOOD CLOTS ❒DIABETES ❒HYPERTENSION ❒STROKE
❒ HEART DISEASE ❒ HEART ATTACK ❒CANCER
❒OTHER_____

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

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

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

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

RESPIRATORY:

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

GENITOURINARY:

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

MUSCULOSKELETAL:

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

Do you have diabetes?	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

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

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

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

HEMATOLOGIC / LYMPHATIC:

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

EXTREMITIES:

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

Patient Registration Form
DAVID BLOOME, MD
Fondren Orthopedic Group

Date: _____ **New Patient: _____**
Update: _____

PLEASE COMPLETE ENTIRE FORM **PATIENT INFORMATION**

NAME: _____
(LAST NAME) (FIRST NAME) (INITIAL)
ADDRESS: _____

DOB: _____ AGE: ___ MALE / FEMALE MARITIAL STATUS: _____ HOME PHONE#: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE#:_____CELL#:_____

EMPLOYER: _____ OCCUPATION: _____ WORK PHONE#: _____

EMAIL ADDRESS: _____@_____._____

PLEASE PROVIDE US WITH YOUR PHARMACY NAME AND PHONE NUMBER SO WE MAY ADD IT TO YOUR FILE.
NAME: _____ PHONE: _____

REFERRED TO THIS OFFICE BY: _____ PHONE: _____

INSURANCE INFORMATION
** PLEASE ALLOW US TO PHOTOCOPY YOUR CURRENT INSURANCE CARD AND DRIVER'S LICENSE**

PRIMARY INSURANCE: _____ PATIENT HOLDS POLICY: YES NO

IF NOT, WHO HOLDS POLICY: _____ DOB: _____ SSN#:_____

RELATIONSHIP TO PATIENT: PARENT SPOUSE GUARDIAN

EMPLOYER: _____ ❒ SAME AS ABOVE GUARANTOR PHONE#: _____

SECONDARY INSURANCE: _____ PATIENT HOLDS POLICY: YES NO

IF NOT, WHO HOLDS POLICY: _____ DOB: _____ SSN#:_____

RELATIONSHIP TO PATIENT: PARENT SPOUSE GUARDIAN

EMPLOYER: _____ ❒ SAME AS ABOVE GUARANTOR PHONE#: _____

IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP TO PATIENT: _____ PHONE#: _____

ASSIGNMENT AND RELEASE

This signature will authorize Fondren Orthopedic Group L.L.P, physicians to provide the indicated medical/surgical care necessary for my treatment. Should it be necessary, I hereby authorize my insurance to pay directly to Fondren Orthopedic Group L.L.P., all benefits otherwise payable to me under the provisions of this policy. I also authorize the release of all medical information to the insurance company that is required to process all claims. I understand this authorization may be mailed or faxed to my insurance company.

SIGNATURE OF INSURED: _____ DATE: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any amount consistent with the contract or limits defined within your insurance plan. In order to control costs of billing, we request that charges for office visits be paid at the conclusion of each office visit.**