

**James B. Duke, M.D., P.A.**

**Health History**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

WORK COMP CASE:  YES  NO LITIGATION PENDING/COMTEMPLATED:  YES  NO

MOTOR VEHICLE ACCIDENT  YES  NO

SPORTS IN WHICH YOU PARTICIPATE \_\_\_\_\_

BODY PARTS EFFECTED:  SHOULDER  ELBOW  FOREARM  WRIST

HIP  THIGH  KNEE  LEG

OTHER \_\_\_\_\_

SIDE EFFECTED:  RIGHT  LEFT  BILATERAL (BOTH) DOMINANT ARM:  RIGHT  LEFT

**PAIN SYMPTOMS: PLEASE CHECK ONLY SIGNIFICANT SYMPTOMS**

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> PAIN             | <input type="checkbox"/> RADIATING         | <input type="checkbox"/> POPPING SENSATION | <input type="checkbox"/> STIFFNESS    |
| <input type="checkbox"/> ACHING           | <input type="checkbox"/> SHARP             | <input type="checkbox"/> GIVING WAY        | <input type="checkbox"/> SWELLING     |
| <input type="checkbox"/> ACTIVITY RELATED | <input type="checkbox"/> SPASM             | <input type="checkbox"/> GRINDING          | <input type="checkbox"/> TENDERNESS   |
| <input type="checkbox"/> BURNING          | <input type="checkbox"/> THROBING          | <input type="checkbox"/> INSTABILITY       | <input type="checkbox"/> INABILITY TO |
| <input type="checkbox"/> DULL             | <input type="checkbox"/> TINGLING/NUMBNESS | <input type="checkbox"/> LIMITED RANGE     | PERFORM SPORT                         |
| <input type="checkbox"/> NIGHT TIME       | <input type="checkbox"/> WEAKNESS          | OF MOTION                                  |                                       |
| <input type="checkbox"/> POST ACTIVITY    | <input type="checkbox"/> WALKING PROBLEM   | <input type="checkbox"/> SORENESS          |                                       |

DATE OF INJURY (OR WHEN PROBLEMS BEGAN): \_\_\_\_\_

DESCRIBE INJURY/INJURIES, OR PROBLEM: \_\_\_\_\_

OTHER DOCTORS SEEN FOR THIS PROBLEM, WHO AND WHEN \_\_\_\_\_

PHYSICAL THERAPY:  YES  NO MEDICATION:  YES  NO NAME: \_\_\_\_\_

CORTISONE SHOTS:  YES  NO HOW MANY? \_\_\_\_\_ DID YOU BRING RECORDS?  YES  NO

**CURRENT DAILY** NAME OF DRUG \_\_\_\_\_ DOSAGE \_\_\_\_\_ TIMES PER DAY \_\_\_\_\_

**MEDICATIONS:** NAME OF DRUG \_\_\_\_\_ DOSAGE \_\_\_\_\_ TIMES PER DAY \_\_\_\_\_

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OTHER HEALTH OR MEDICAL PROBLEMS: \_\_\_\_\_

PLEASE LIST ALL PREVIOUS SURGERY, DATE, AND WHAT WAS DONE

TYPE OF SURGERY: \_\_\_\_\_ YEAR \_\_\_\_\_ WHERE DONE? \_\_\_\_\_

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OTHER (PLEASE LIST ALL PREVIOUS HOSPITALIZATIONS) \_\_\_\_\_

ALLERGIES (MEDICINES, FOODS, POLLENS) IF YES, PLEASE LIST: \_\_\_\_\_

SMOKE?  YES  NO AMT/DAY \_\_\_\_\_ DRINK?  YES  NO AMT/DAY \_\_\_\_\_

## **PATIENT CONSENT FORM**

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can so secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment of health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### **COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS**

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patient inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule" We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.