HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

Acknowledgment for Receipt of Notice of Privacy Practices

I have been given a copy of the Notice of Privacy Practices for Houston Methodist Physician Organization and its Physicians. This Notice describes my legal rights regarding my health information and informs me of the legal duties and privacy practices of Houston Methodist Physician Organization and its Physicians with respect to health information created for services generated by Houston Methodist Physician Organization and its Physicians.

_____ _____
Signature of Patient or Patient's Qualified Personal Representative* Date

* In the event the patient is legally unable to sign, please print the name of the patient's Qualified Personal Representative and the individual's legal authority to act on behalf of the patient.

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient _____

CONSENT TO TREAT

I voluntarily consent to the physicians and other clinical personnel of The Methodist Hospital, Department of Orthopedics, for the evaluation and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of The Methodist Hospital, Department of Orthopedics and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at The Methodist Hospital, Department of Orthopedics. I understand that this consent may be revoked in writing at any time.

_____ _____
Printed Patient Name Patient Date of Birth

_____ _____
Signature of Patient or Guarantor, if minor Date Signed

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to The Methodist Hospital, Department of Orthopedics, realizing I am responsible to pay non-covered services. I certify that the information given by me to The Methodist Hospital, Department of Orthopedics, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THIS INFORMATION.

_____
Printed Patient Name

_____ _____
Signature of Patient or Guarantor, if minor Date Signed

HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

Preferred Method of Telephone Contact

If we need to contact you regarding test results, referrals, appointments, or other medical or billing information, please indicate below how you wish to be called. **Please check all that apply and indicate below** whether we may discuss your medical and billing information with family members or other individuals.

Home Telephone _____

Cell Phone Number _____

- ❑ Leave **only a call-back name and telephone number** on my answering machine or with any person who answers the telephone.
- ❑ Leave a **detailed message** on my answering machine.
- ❑ **Do not** leave any type of message or call-back information if I am not there.

Work Telephone _____

- ❑ Leave only a **call-back name and telephone number** on my voice mail or with any person who answers the telephone.
- ❑ Leave a **detailed message** on my voice mail or answering machine.
- ❑ **Do not** leave any type of message or call-back information if I am not there.

Discussion of Medical and Billing Information with Family Members and Other

❑ You may also discuss my medical and billing information with my family members and with other individuals I have listed below.

Name	Relationship	Telephone Number (s)

_____ _____

Signature of Patient or Patient's Qualified Personal Representative* Date

* In the event the patient is legally unable to sign, please print the name of the patient's Qualified Personal Representative and the individual's legal authority to act on behalf of the patient.

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient _____

HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

PATIENT REGISTRATION

Name:(Last)_____(First)_____(MI)_____

DOB: _____ SSN _____ Sex: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip:_____ Country: _____

Primary Phone:_____ __ Hm __Cell:_____ Work: _____

Which phone may we leave a message regarding your appointments? ___ Primary ___Cell ___Hm ___Wk

May we contact you via email? __ Y __ N /E-mail: _____

Employer Name & Address: _____

Occupation: _____ Referred by:_____

Is this visit due to a ___Personal Injury ___Automobile Accident ___Work Related Injury
Date of Injury_____

EMERGENCY CONTACT

Name:_____Relationship_____Phone:_____

INSURANCE (Required for proper billing)

Primary Insurance:_____

Subscriber Name:_____ SSN:_____ DOB:_____

Relationship to Patient: ___Self ___Spouse ___Child Other:_____

ID # _____Group #_____ Benefits Phone_____

Secondary Insurance:_____

Subscriber Name:_____ SSN:_____ DOB:_____

Relationship to Patient: ___Self ___Spouse ___Child Other:_____

ID # _____Group #_____ Benefits Phone_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Houston Methodist or insurance company to release any information required to process my claims.

Signature of Patient or Guardian_____ Date_____

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Fax: 713-790-5134
www.methodistorthopedics.com

GENERAL INTAKE SURVEY

Last name _____ First name _____ Middle name _____

Today's date __/__/__ Date of birth __/__/__ Male / Female Height __ ft __ in Weight ___ lbs

Occupation _____ E-mail address _____

What joint are you being evaluated for today? ___ Shoulder; ___ Knee; ___ Hip; ___ Elbow; ___Other

Past Medical History

Have you ever been treated for any of the following illnesses? Please check all that apply.

	Heart disease		Diabetes		Seizures/Epilepsy
	Heart failure		Stroke/Mini-stroke		Ulcers
	Heart attack		Hepatitis		Anxiety
	High blood pressure		Immunodeficiency		Depression
	High cholesterol		Bleeding disorders		Fibromyalgia
	Emphysema/bronchitis/asthma		Clotting disorders		Thyroid disease
	Cancer		Arthritis		Other

Please list any other medical illnesses or condition not listed above:

_____

_____

Do you have a family history of any medical problems? ___ Yes ___ No

If yes, please list them here: _____

Please list your prior surgeries (and dates/years) here:

_____

_____

Have you ever had problems with general anesthesia? ___ Yes ___ No

If yes, please describe the problem here: _____

Do you currently smoke cigarettes? ___ Yes ___ No; How many packs/day? ___ How many years? ___

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Please list any current medications, including over-the-counter medications and supplements:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Do you have any allergies to medications? ___ Yes ___ No

If yes, please list allergies here:

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any allergies to latex? ___ Yes ___ No

Do you have any other allergies not listed above? ___ Yes ___ No

If yes, please list here:

1. _____
2. _____
3. _____

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Review of Systems - Please circle any item that applies to you or circle "no problems" if you have no problems.

1. Constitutional (General health): No problems;
    a. Lack of energy, fatigue, excessive sleepiness, unintentional weight gain or weight loss, appetite loss, fever, chills, night sweats.
2. Eyes, ears, nose, mouth, throat: No problems;
    a. Double vision, blurry vision, vision loss, near sighted, far sighted, astigmatism, poor hearing, ringing in ears, sinus problems, nosebleeds, runny nose, post-nasal drip, mouth or throat sores, difficulty swallowing.
3. Cardiovascular (heart and blood vessels): No problems;
    a. Irregular heartbeat, heartbeat too fast or slow, chest pain, swollen legs or feet, pain in legs with walking.
4. Respiratory (lungs and breathing): No problems;
    a. Shortness of breath, cough, wheezing, pleurisy, use of oxygen at home during day or night, use of CPAP, coughing up blood.
5. Gastrointestinal (stomach, intestines): No problems;
    a. Heartburn, ulcers, reflux, nausea, vomiting, constipation, diarrhea, incontinence, abdominal pain, intolerance to certain foods, blood in stool, black tarry stools.
6. Genitourinary (bladder and kidneys): No problems;
    a. Painful urination, frequent urination, incontinence, urgency, bladder problems, kidney stones, prostate problems.
7. Musculoskeletal (muscles, tendons, bones, joints): No problems;
    a. Pain in arm or legs, aching muscles or joints, swollen arms or legs, swollen joints, back pain, neck pain.
8. Integumentary (skin and nails): No problems;
    a. Rash, itching, skin lesion, new moles or skin lesions, change in existing moles or skin lesions, excessive loss or gain of hair.
9. Neurologic (brain or nerves): No problems;
    a. Headaches, double vision, blurry vision, vision loss, weakness, numbness or tingling, difficulty walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions.
10. Psychiatric (emotions, mood, thinking): No problems;
    a. Depression, anxiety, panic attacks, insomnia, irritability, recurrent bad thoughts, mood swings, hallucinations, delusions, obsessions, compulsions.
11. Endocrine (glands): No problems;
    a. Thyroid problems, intolerance to heat or cold, menstrual irregularities, frequent hunger or thirst, change in sex drive.
12. Hematologic (blood and lymph): No problems;
    a. Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, lymphoma, myeloma, unexplained swollen lymph nodes.
13. Allergic or immunologic: No problems;
    a. Seasonal allergies, food allergies, latex allergies, pet allergies, hay fever, itching, frequent infections, exposure to HIV or hepatitis.
14. Other: _____
    _____
    _____

SF-12v2™ Health Survey

(SF-12 v2 Standard, US Version 2.0)

To be completed by the PATIENT

Identification Number
Event

Directions: *This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. If you need to change an answer, completely erase the incorrect mark and fill in the correct circle. If you are unsure about how to answer a question, please give the best answer you can.*

Today's Date (MM/DD/YY)

__ __ / __ __ / __ __

Shade circles like this: ● **Not like this:** ⊗ ✓

Mark only one answer for each question. Please do not mark outside the circles or make stray marks on the questionnaire.

	Excellent	Very Good	Good	Fair	Poor
01. In general, would you say your health is:	○	○	○	○	○

The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, not limited at all
02. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
03. Climbing several flights of stairs	○	○	○

During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
04. Accomplished less than you would like	○	○	○	○	○
05. Were limited in the kind of work or other activities	○	○	○	○	○

During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
06. Accomplished less than you would like	○	○	○	○	○
07. Did work or activities less carefully than usual	○	○	○	○	○

	Not at all	A little bit	Moderately	Quite a bit	Extremely
08. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?	○	○	○	○	○

These questions are about how you feel and how things have been with you during the <u>past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks...</u>	All of the time	Most of the time	Some of the time	A little of the time	None of the time
09. Have you felt calm and peaceful	○	○	○	○	○
10. Did you have a lot of energy	○	○	○	○	○
11. Have you felt downhearted and depressed	○	○	○	○	○
12. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, etc.)?	○	○	○	○	○

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TEGNER ACTIVITY LEVEL SCALE

Please indicate in the spaces below the HIGHEST level of activity that you participated in BEFORE YOUR INJURY and the highest level you are able to participate in CURRENTLY.

BEFORE INJURY: Level_____ CURRENT: Level_____

Level 10	**Competitive sports- soccer, football, rugby (national elite)**
Level 9	**Competitive sports- soccer, football, rugby (lower divisions), ice hockey, wrestling, gymnastics, basketball**
Level 8	**Competitive sports- racquetball or bandy, squash or badminton, track and field athletics (jumping, etc.), down-hill skiing**
Level 7	**Competitive sports- tennis, running, motorcars speedway, handball** **Recreational sports- soccer, football, rugby, bandy, ice hockey, basketball, squash, racquetball, running**
Level 6	**Recreational sports- tennis and badminton, handball, racquetball, down-hill skiing, jogging at least 5 times per week**
Level 5	**Work- heavy labor (construction, etc.)** **Competitive sports- cycling, cross-country skiing,** **Recreational sports- jogging on uneven ground at least twice weekly**
Level 4	**Work- moderately heavy labor (e.g. truck driving, etc.)**
Level 3	**Work- light labor (nursing, etc.)**
Level 2	**Work- light labor** **Walking on uneven ground possible, but impossible to back pack or hike**
Level 1	**Work- sedentary (secretarial, etc.)**
Level 0	**Sick leave or disability pension because of knee problems**

Y Tegner and J Lysolm. ***Rating Systems in the Evaluation of Knee Ligament Injuries.*** **Clinical Orthopedics and Related Research. Vol. 198: 43-49, 1985.**

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Foot and Ankle Questionnaire

Instructions

Please answer the following questions for the foot/ankle being treated or followed up. If it is BOTH feet/ankles, please answer the questions for your **worse** side. All questions are about how you have felt, on average, during the **past week**. If you are being treated for an injury that happened less than one week ago, please answer for the period since your injury.

1. During the **past week**, how **stiff** was your foot/ankle? (Circle one response.)

1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

2. During the **past week**, how **swollen** was your foot/ankle? (Circle one response.)

1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

During the **past week**, please tell us about how painful your foot/ankle was during the following activities. (Circle ONE response on each line that best describes your average ability.)

	Not painful	Mildly painful	Moderately painful	Very painful	Extremely painful	Could not do because of foot/ankle pain	Could not do for other reasons
3. Walking on **uneven** surfaces?	1	2	3	4	5	6	7
4. Walking on **flat** surfaces?	1	2	3	4	5	6	7
5. Going up or down stairs?	1	2	3	4	5	6	7
6. Lying in bed at night?	1	2	3	4	5	6	7

During the **past week**, did your foot/ankle **give way** during the following activities. (Circle ONE response on each line that best describes you for each activity level.)

	Did not give way at all	Partially gave way, but I did not fall	Completely gave way, so that I fell	Could not do the activity because of foot/ankle giving way	Could not do for other reasons
7. **Strenuous activity**, such as heavy physical work, skiing, tennis?	1	2	3	4	5
8. **Moderate activity**, such as moderate physical work, jogging, running?	1	2	3	4	5
9. **Light activity**, such as walking, house work, yard work?	1	2	3	4	5

10. Which of the following statements **best** describes your ability to get around most of the time during the **past week**? (Circle one response.)

1 I did not need support or assistance at all.
2 I mostly walked without support or assistance.
3 I mostly used one cane or crutch to help me get around
4 I mostly used two canes, two crutches or a walker to help me get around.
5 I used a wheelchair.
6 I mostly used other supports or someone else had to help me get around.
7 I was unable to get around at all.

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Foot and Ankle Questionnaire

11. How much trouble did you have with balance during the **past week**? (Circle one response.)

1 No trouble at all
2 A little bit of trouble
3 A moderate amount of trouble
4 Quite a bit of trouble
5 A great amount of trouble
6 I cannot balance on my feet at all

12. How difficult was it for you to put on or take off socks/stockings during the **past week**? (Circle one response.)

1 Not at all difficult 2 A little bit difficult 3 Moderately difficult 4 Very difficult 5 Extremely difficult 6 Cannot do it at all

All questions are about how you have felt on average **during the past week**.

During the **past week**, please tell us about how **painful** your **foot or ankle** was when you were performing the following activities. (Circle ONE response on each line that best describes your average ability.)

	No pain	Mild pain	Moderate pain	Severe pain	Extreme pain	Could not do because of foot/ankle pain	Could not do for other reasons
13. Strenuous activity, such as heavy physical work, skiing, tennis	1	2	3	4	5	6	7
14. Moderate activity, such as moderate physical work, jogging, running	1	2	3	4	5	6	7
15. Light activity, such as walking, house work, yard work	1	2	3	4	5	6	7
16. Standing for an hour	1	2	3	4	5	6	7
17. Standing for a few minutes	1	2	3	4	5	6	7

18. How much difficulty do you have walking on uneven surfaces (eg., small stones, rocks, sloping ground)? (Circle one response.)

1 No difficulty
2 Mild difficulty
3 Moderate difficulty
4 Severe difficulty
5 Extreme difficulty
6 Cannot do because of foot/ankle
7 Cannot do for other reasons

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Foot and Ankle Questionnaire

What types of shoes can you wear comfortably?
(Circle one response on each line.)

	Yes	No	Not applicable
19. Any women's shoe (including high heels) OR any men's shoe (including fancy dress shoes)	1	2	3
20. Most women's dress shoes (except high heels) OR most means dress shoes	1	2	3
21. Sneakers, walking, or casual shoes	1	2	3
22. Orthopaedic or prescription shoes	1	2	3
23. All shoes	1	2	3

24. How much did your foot or ankle problem interfere with your normal work, including work both outside the home and house work? (Circle one response.)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely 6 Unable to work due to foot and ankle problems

25. How much did your foot or ankle problem interfere with your life and your ability to do what you want? (Circle one response.)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely 6 It ruins everything