MCMC MID-COLUMBIA MEDICAL CENTER | SPORTS MEDICINE AND ORTHOPAEDIC SURGERY

NEW PATIENT DEMOGRAPHICS QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ DOB: _____

Race

☐ White/Caucasian ☐ Black/African American ☐Asian ☐Native American
☐ Alaskan Native ☐Native Hawaiian ☐ Pacific Islander ☐ Other: _____

Preferred Language:

☐ English ☐ Spanish ☐ Sign Language ☐ Other: _____

Ethnicity:

Hispanic ☐ Yes ☐ No

Migrant and Seasonal Employment:

Have you or someone in your household ever been employed in agriculture/farming?
☐Yes ☐ No

In the past two years, have you or someone in your household moved to another area (established a temporary home) in order to work in agriculture?
☐Yes ☐ No

In the past two years, have you or someone in your household worked in agriculture without the need to move away from your home? ☐ Yes ☐ No

Have you or someone in your household stopped traveling to work in agriculture because of retirement or a disability?
☐ Yes ☐ No

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

_____ _____

Patient Signature Date

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For Office Use	Room #
Height: _____	Weight: _____
BP: _____	Pulse _____

NEW PATIENT MEDICAL HISTORY **Date**_____

Name: _____ **DOB**_____ **Age:** _____

Family Members seen in this office**:** _____

Primary Care Physician: _____

Who requested you visit this office: ☐ MD ☐ Coach ☐ Family ☐ ER ☐ Other: _____

Name of School/Team/Home town: _____ Coach's Name: _____

Occupation: _____Employer:_____

Which body part have you scheduled for treatment? Please circle.

Toe Heel Foot Ankle Leg Hand Knee Thigh Hip Back Neck Shoulder Clavicle Arm Elbow Wrist Finger Other: _____

Right **Left** **Bilateral**

Date of Injury / Onset of symptoms: _____ If injury, describe how it occurred:

_____

_____

_____

Describe symptoms: _____

_____

_____

_____

_____

Severity: What is the severity of your pain? (Scale of 0-10)_____

Quality: What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Burning

Timing: The pain is: ☐ Constant ☐ Intermittent Does the pain wake you from sleep? ☐ Yes ☐ No

Context: Since my problem started it is : ☐ Getting better ☐ Getting worse ☐ Unchanged

Associated symptoms: Do you have? ☐ Swelling ☐ Bruising ☐ Weakness ☐ Numbness ☐ Tingling

Modify: What makes your symptoms worse? ☐Standing ☐ Walking ☐ Stairs ☐ Squatting ☐ Kneeling ☐ Twisting ☐ Bending ☐ Sitting ☐ Exercise ☐ Lifting ☐ Overhead Activities ☐ Coughing / Sneezing

What makes your symptoms better? ☐Ice ☐ Heat ☐ Rest ☐ Elevation

What medications are you taking now or previously for this problem? _____

Have you been treated for this condition? ☐ Yes ☐ No Emergency Room ☐ Yes ☐ No

Describe treatment:

_____

_____

_____

_____

_____

_____

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Patient Name:_____

Date of Birth:_____

Please indicate by circling below if you have experienced any of the following symptoms:

SYMPTOM: *Circle* symptom below	If *NONE*, check box below
Gastrointestinal (GI): Heartburn / Ulcers	☐
Cardiac: Chest Pain / Palpitations	☐
Respiratory: Shortness of Breath / Chronic Cough	☐
Musculoskeletal: Swelling of Extremity / Increased Weakness	☐
General: Fever / Chills / Rashes	☐
Neurological: Numbness / Tingling / Radicular Pain	☐
Hematology: Pulmonary Embolus / Deep Venous Thrombosis	☐
Genitourinary (GU): Blood in Urine / Kidney Stones	☐
Psychiatric: Depression / Sleep Disturbances	☐
Ears, Nose Throat (ENT): Sore Throat / Hearing Changes	☐
Eyes: Blurry Vision / Double Vision	☐
Allergy: New Drug Allergy / Other	☐

Work Status: If applicable

What is your current job status?

__ Not Currently Employed **__Regular Duty** **__Light Duty**

__ Not working due to this condition **__Retired** **__Student**

When do you expect to return to full duty?_____

When do you expect to return to work? _____

Signature_____Date_____

MCMC MID-COLUMBIA MEDICAL CENTER | SPORTS MEDICINE AND ORTHOPAEDIC SURGERY
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A DESIGNATED PLANETREE PATIENT-CENTERED HOSPITAL

AUTHORIZATION FOR ACCESS TO PROTECTED HEALTH INFORMATION

This authorization must be written, dated and signed by the patient, or by a person authorized by law to give authorization. If this authorization is for psychotherapy notes, it must not be used for any other type of protected health information.

This information will be disclosed to and/or received by persons who are not subject to federal health information privacy laws. These persons may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. You are not obligated to authorize the disclosure.

Printed Name: _____ Date of Birth: _____

I authorize Orthopedic Services at MCMC to grant verbal access to the protected health information in my current Clinic Medical Record Chart to assist me during the time I am receiving care from the Outpatient Clinic practitioners. The Outpatient Clinics are comprised of: Columbia Hills Family Medicine, Columbia Crest Clinic, Columbia River Women's Center, Columbia View Clinic, Water's Edge Medical Clinic, River View Clinic, Columbia Crest Dermatology, Orthopedic Services at MCMC, Gorge Urology, Healthy Weight and Treatment Center and MCMC Occupational Health.

Primary: _____
(Name of person who will have access) Relationship

Secondary: _____
(Name of person who will have access) Relationship

By initialing the spaces below, I specifically authorize access to the following protected health information, if such information exists.

_____ Financial, Insurance or Billing information
_____ Clinical Information from my medical record chart

These specially protected items must be individually initialed to include them in the release or access to information either clinical or financial:
_____ HIV/AIDS-related records
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment or referral information
_____ Mental health information, psychotherapy notes (requires separate form)

You have the right to inspect or receive a copy of the information in your medical record. You have a right to a copy of this authorization. You may revoke this authorization at any time by giving written notice to a staff member, who will make the change in your chart. You have the right to limit the time that this agreement will remain in effect by entering an expiration date here: _____

_____ Date: _____
(Signature of Patient)

_____/_____ Date: _____
(Signature of person legally authorized to sign for patient) / Relationship

Document verification of ID of person who has been given access.
Include this authorization in the patient's medical record.