IASM The Institute for Arthroscopy & Sports Medicine, San Francisco

Dr. Jeffrey Halbrecht MEDICAL DIRECTOR

PATIENT QUESTIONNAIRE

PLEASE PROVIDE US WITH THE FOLLOWING IMPORTANT INFORMATION. WE NEED THIS INFORMATION TO GIVE YOU THE BEST CARE AND TREATMENT POSSIBLE. ALL INFORMATION IS HELD STRICTLY CONFIDENTIAL.

NAME: _____ AGE: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ _____RIGHT HANDED _____LEFT HANDED

PART I

DATE OF COMPLAINT/INJURY: _____ LAST DAY WORKED: _____

WHAT BODY PART IS PAINFUL AND/OR INJURED:_____

RIGHT LEFT BOTH (CIRCLE ONE)

PRESENT COMPLAINT: PLEASE DESCRIBE TO THE BEST OF YOUR ABILITY YOUR CURRENT PROBLEM. INCLUDE DETAILS OF HOW AND WHEN YOUR INJURY OR PROBLEM OCCURRED AND YOUR PRESENT SYMPTOMS.

_____

_____

_____

PREVIOUS TREATMENT AND CARE FOR THIS INJURY/COMPLAINT. PLEASE INCLUDE: X-RAY, MRI, PHYSICAL THERAPY, MEDICATIONS, ECT…

_____

_____

_____

HAVE YOU HAD A PREVIOUS INJURY/COMPLAINT IN THIS AREA? _____YES _____NO

IF YES, PLEASE DESCRIBE: _____

YOUR PRESENT OCCUPATION: _____

SPORTS/LEISURE ACTIVIES: _____

LEVEL OF ACTIVITY LOW MODERATE HIGH (circle one)

PART II -PAST MEDICAL HISTORY

HAVE YOU EVER HAD SURGERY? _____YES _____NO
IF YES, PLEASE EXPLAIN (YEAR/TYPE): _____
_____
_____

HAVE YOU EVER HAD:

_____YES _____NO CANCER
_____YES _____NO HEART TROUBLE
_____YES _____NO DIFFICULTY WITH BREATHING (including sleep apnea)
_____YES _____NO LUNG DISEASE (i.e. pneumonia, asthma, emphysema)
_____YES _____NO JAUNDICE, HEPATITIS
_____YES _____NO DIABETES
_____YES _____NO FAINTING SPELLS
_____YES _____NO ALLERGIES
_____YES _____NO HIGH BLOOD PRESSURE
_____YES _____NO ANEMIA OR BLEEDING PROBLEMS
_____YES _____NO FRACTURES/BROKEN BONES OR TRAUMA_____
_____YES _____NO PULMONARY EMBOLISM OR BLOOD CLOTS
_____YES _____NO OTHER SERIOUS HEALTH PROBLEMS _____
_____
_____POSITVE_____NEGATIVE HIV STATUS (IF KNOWN)

ALLERGIES:

ALLERGIES TO MEDICATIONS _____YES _____NO
IF YES, PLEASE LIST MEDICATION NAME AND TYPE OF REACTION(S) _____
_____
_____

ALLERGIES TO OTHER SUBSTANCES _____YES _____NO
IF YES, PLEASE LIST _____
_____

MEDICATIONS:

DO YOU TAKE MEDICATIONS REGULARLY (including birth control): _____YES _____NO

NAME	**DOSE**
_____	_____
_____	_____
_____	_____

_____YES _____NO SMOKE _____PACKS PER DAY
_____YES _____NO DRINK ALCOHOL (if so, do you drink daily, socially, occasionally, or rarely)

HAS ANY MEMBER OF YOUR FAMILY EVER HAD:

_____YES _____NO CANCER
_____YES _____NO HEART DISEASE
_____YES _____NO DIABETES
_____YES _____NO LUNG DISEASE, TB, etc.
_____YES _____NO OTHER_____

TO OUR PATIENTS

There are over 1000 insurance plans in America. Therefore, it is impossible for our office to know the covered benefits of you insurance plan. It is the responsibility of the patient to know and understand the policies and benefits of their insurance. This includes:

1. Required referrals obtained and presented prior to rendered
2. Co-Payments
3. Covered hospital/lab/x-rays
4. Prior authorizations procedures
5. Current claim address
6. Any changes of address and/or insurance information

MISSED APPOINTMENT POLICY

Due to our high volume in patient care, we are able to serve all our patients better by keeping our appointment schedule. If you do not keep your appointment, we cannot see other patients who need care. Unless cancelled at least 24 hours in advance, it is our policy to charge twenty-five dollars for missed appointments. You are responsible for paying the missed appointment fee regardless of your insurance coverage. Your insurance will not pay this fee.

I have read and I understand the above missed appointment policy and I agree to accept these terms.

X_____ Date_____

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of Jeffrey L. Halbrecht, M.D., P.C. privacy notice.

X_____ Date_____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTITIVE

_____

RELATIONSHIP TO PATIENT

PATIENT DISCLOSURE

Dear Patient,

California Law imposes disclosure requirement for Physicians that have a financial interest in a facility to which they refer patients. In compliance with the law, please be advised that if you need surgical treatment, Dr. Jeffrey Halbrecht has financial interest in Pacific Height Surgery of San Francisco, where your surgery will be preformed.

If you prefer your surgery NOT be performed at Pacific Heights, please let our office know so that we can make other arrangements for you.

By signing below you acknowledge that you have read and understand the above.

X_____ Date_____