HOUSTON
Methodist
ORTHOPEDICS & SPORTS MEDICINE

New Patient Questionnaire
Rex Marco, MD

To be completed by office staff-
W: __________ H: __________
BMI: __________ SH: __________

Name:____ **DOB:**____________________

Age _____ **Referring doctor or friend** ____

Main problem or complaint (list previous treatments):

Do you have any MRI's, X-rays, or CT scans?:______________ Date:____________________

Are you allergic to any medications? No Yes **List medication:**____________________

List all current prescription and over the counter medications you take (use additional sheet if necessary):

Circle any current or past medical problems:

Cancer Heart attack Blood clots High blood pressure Bleeding Diabetes Asthma

HIV Stroke Seizures Kidney problems Reflux Ulcers Hepatitis

List other current and past medical problems (use additional sheet if necessary):

Past Surgical History (use additional sheet if necessary):

Circle any problems you currently have:

		Fever	Chills
Chest Bruising	Loss of bladder control	Blood in Urine	Weight loss
Coughing Blood	Anxiety	Depression	Palpitations
Leg swelling	Loss of bowel control	Blurry vision	Shortness of breath
Bleeding gums	Enlarged lymph nodes	Slurred speech	Blood in stool

Do bleeding problems run in your family? No Yes

Are you taking aspirin or any blood thinners? No Yes (please list) ____________________

Do you smoke, chew tobacco, or use any other nicotine product? No Yes __________packs/day

Do you drink alcohol regularly? No Yes __________amount **Height:**______________

Do you use illicit drugs? No Yes __________amount **Weight:**______________

Are you employed? No Yes

If no, is it due to the condition you are being see for today? No Yes

If yes, occupation?____

X____

Signature: Patient or patient's agent **Date**

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New Patient Questionnaire
Rex Marco, MD

Medications, continued:

Other current and passed medical problems, continued:

Other surgical history, continued:

PAIN DRAWING

NAME: (please print)____ DOB:____________

X ____

Signature: Patient or patient's agent **Date**

How long have you experienced neck/back pain? _____ Years _____ Months _____ Weeks

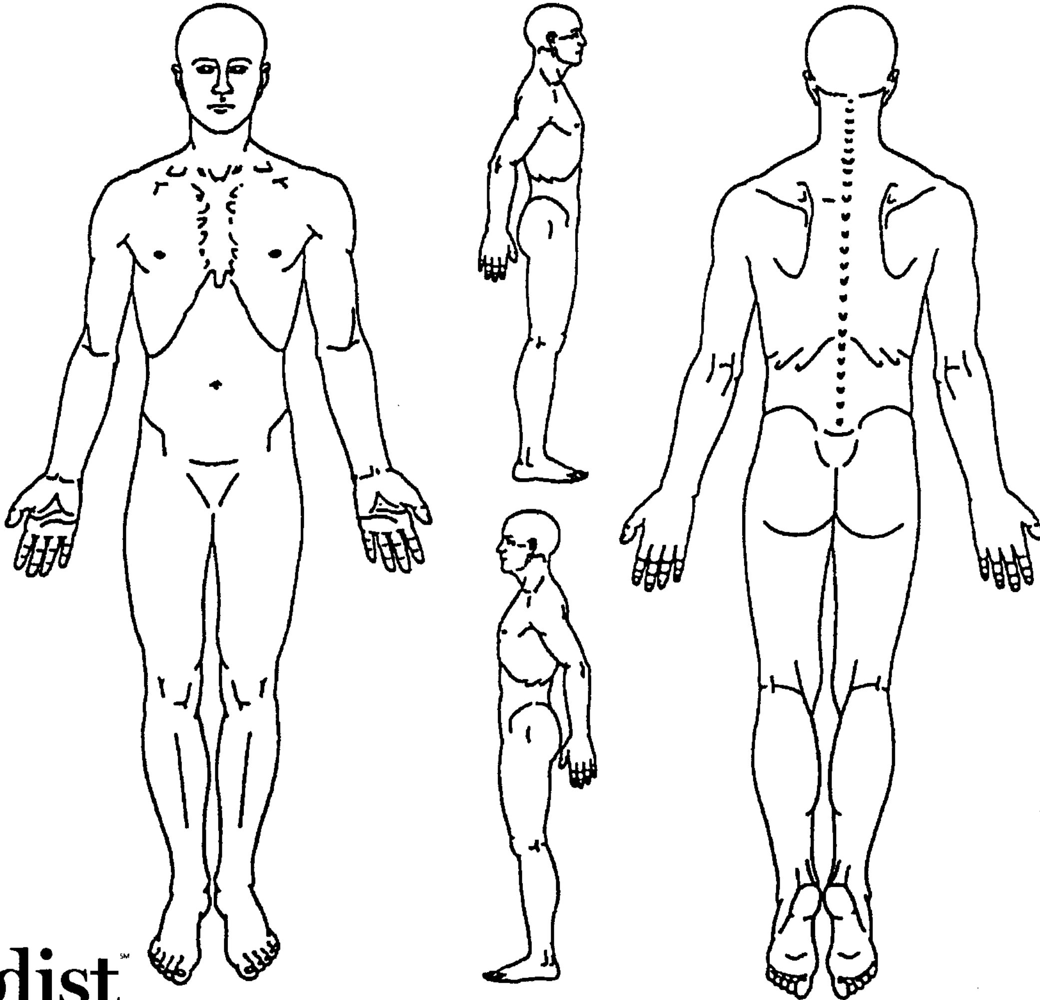
Is this your first episode of neck/back pain? _____ YES _____ NO

Please indicate how you would rate your pain

(LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



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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

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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 ____________________

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Spine Surgery Nonoperative Management Prior to Surgical Intervention

Medications (Please include dates of use with start and stop dates as close as possible)

1. **Anti-inflammatories** (examples: ibuprofen, Advil, Aleve, Mobic, Celebrex, Medrol Dose Pack, etc.)
2. **Pain Medications**
3. **Muscle Relaxers**

Physical therapy or chiropractic treatment (Please include the date range of trials-MUST BE 12 WEEKS)

1.
2.

Assistive Devices (please circle) Cane Walker Crutches External bracing TENS unit Traction

Interventional Pain Management (include facet injections, epidural injections, Spinal Stimulator, Pain Pump (please include the dates, physician name and procedure notes to our office))

1.
2.
3.

Lifestyle Modifications (please circle) Flexibility/Muscle Strengthening Modification of Activities Weight Loss Loss of Work Time

Signs of Acute Spinal Issues (please circle) Loss of Bowel Function Loss of Bladder Function Spinal Infection Paralysis Progressive Falling Loss of Muscle Function Fever

Prior Surgical Intervention (Please include dates, surgeon and type of surgery)

1.
2.
3.

Please sign below attesting to the validity of this documentation to the best of your knowledge.

Signature:______________________________ Date ______________

Printed Name:______________________________ DOB:______________