Stadia Sports Medicine   Patient Health Questionnaire

Name: ____ DOB: ____________ M / F Date: ____________

Address: ______________________________ City: ___________________________ State: _____ Zip: _________

Email address: ____

Appointment reminders:
☐ Phone English / Spanish
☐ Text English / Spanish

Phone number type:

Preferred phone: (______) _______ - ___________ ☐ Mobile ☐ Home ☐ Work ☐ Other
Secondary phone: (_______) ________ - _____________ ☐ Mobile ☐ Home ☐ Work ☐ Other
Tertiary Phone: (_______) ________ - _____________ ☐ Mobile ☐ Home ☐ Work ☐ Other

Race
☐ American Indian, Alaskan Native
☐ Asian
☐ Black, African American
☐ Black Hispanic/ Latino
☐ Native Hawaiian, Pacific Islander
☐ White
☐ White Hispanic/ Latino
☐ Other
☐ Unknown
☐ Declined to share

Language preference:
☐ English
☐ Spanish
☐ Other: ____________________________

Emergency Contact(s): (and next of kin or additional parents or guardians)

Name: ______________________________ Phone number: (______) _______ - ___________
Relationship to patient: ____

Name: ______________________________ Phone number: (______) _______ - ___________
Relationship to patient: ____

Name: ______________________________ Phone number: (______) _______ - ___________
Relationship to patient: ____

Preferred Pharmacy: _____________________ Pharmacy Address: ___________________________

Primary care physician: ___________________________

Referral Source: ☐ Physician/ Clinic Name ____
☐ Other, (circle) Word of mouth - who? / website / advertising ___________________

Primary Insurance
Company: _______________________
Policy/ Member # __________________
Group # _______________
Billing PO Box: ____________________
Subscriber relationship: __________________
Subscriber Full Name: ___________________
Subscriber DOB: __________________
Subscriber sex: ____ M _____ F
(if different from patient)
Subscriber Address:
____
City, State, Zip:
____

Secondary Insurance
Company: _______________________
Policy/ Member # __________________
Group # _______________
Billing PO Box: ____________________
Subscriber relationship: __________________
Subscriber Full Name: ___________________
Subscriber DOB: __________________
Subscriber sex: ____ M _____ F
(if different from patient)
Subscriber Address:
____
City, State, Zip:
____

Tertiary Insurance
Company: _______________________
Policy/ Member # __________________
Group # _______________
Billing PO Box: ____________________
Subscriber relationship: __________________
Subscriber Full Name: ___________________
Subscriber DOB: __________________
Subscriber sex: ____ M _____ F
(if different from patient)
Subscriber Address:
____
City, State, Zip:
____

Office Use: ☐ AllegianceMD ☐ Pharmacy ☐ INS ☐ Next of Kin ☐ Scanned ☐ Provider Folder
☐ New folder ☐ Tracking ☐ Referral Info ☐ Billing class

Allergies: Are you allergic to any drugs? (circle) No Yes , please list ___________________________________
Are you allergic to latex? No Yes Any other allergies? ___________________________________

Medications: (List all medications you are taking regularly. Include over the counter, herbal or natural remedies.)

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Social History

Occupation: ____ for __________ years

Marital Status: ☐ Married, spouse's name ______________ ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
☐ Yes, I authorize Stadia to discuss my health information with my spouse.
☐ No, do not discuss my health information with my spouse

Do you have any children? ☐ No
☐ Yes, I have _______ (#) children.

Exercise: ☐ Never ☐ Rarely ☐ Weekly ☐ Daily ☐ Other frequency _____times/________
Which kind(s) of exercise? ______________________________________

Do you drink alcohol? ☐ Never ☐ 1 - 2 times per week ☐ 1 -2 times/ year
☐ Daily ☐ 1-2 times per month ☐ Other frequency _____times/________

Have you ever smoked? *(circle)* No Yes Cigar Pipe Cigarettes If Yes: # cigarettes/day _______ #yrs. _______
If you have never smoked, skip this question: Do you still smoke now? Yes No, ______# years quit

Caffeine: Do you drink *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes, ___(#)/day

Family Medical History	Age	Health / Significant Illness	Age at Death	If deceased, cause & comments
Father				
Mother				
Siblings				
Spouse				
Children				
Other				

Has any blood relative ever had? *(check if Yes and indicate relationship)*

☐ Alcoholism ____________ ☐ Depression/Suicide ____________ ☐ Mental disorder ____________
☐ Allergies ____________ ☐ Diabetes ____________ ☐ Seizures ____________
☐ Alzheimer's ____________ ☐ Heart attack before age 55 ____________ ☐ Stroke ____________
☐ Asthma ____________ ☐ Heart disease ____________ ☐ Thyroid disease ____________
☐ Bleeding disease ____________ ☐ High blood pressure ____________ ☐ Tuberculosis ____________
☐ Cancer :_________ ____________ ☐ High cholesterol ____________ ☐ Other: ________ ____________

Surgical History:

Do you have any metal in your body? ☐ Yes ☐ No

☐ Appendix ☐ Hernia repair ☐ Prostate ☐ Colonoscopy
☐ Gallbladder ☐ Coronary Artery ☐ Joint - knee / hip / shoulder ☐ Other: __________________
☐ Hysterectomy ☐ Carotid Artery ☐ Heart catheterization

Year	Surgery	Year	Hospitalizations
_____	______________________	_____	______________________
_____	______________________	_____	______________________
_____	______________________	_____	______________________

Reason for Visit

I am here to be seen for : ____

When and how did the problem start? ____

Have you received any tests or treatments for this issue? ☐ No ☐ Yes, please explain: ______________________

____

____

____

Medical Illnesses or Conditions

(list any chronic conditions which you have been diagnosed to have)

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Past Medical History (check all that apply):

Cardiovascular
- ☐ Abnormal heart rhythm
- ☐ Abnormal heart valve
- ☐ Chest pain/Angina
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Shortness of breath with walking or lying flat
- ☐ Waking at night with shortness of breath
- ☐ Swelling feet, ankles or hands
- ☐ Other: ____________

Musculoskeletal
- ☐ Arthritis
- ☐ Bone or Joint disease
- ☐ Chronic back pain
- ☐ Joint pain(s)
- ☐ Joint stiffness/swelling/warmth
- ☐ Muscle pain or recurrent cramps
- ☐ Back pain
- ☐ Cold hands or feet
- ☐ Difficulty in walking
- ☐ Other: ____________

Gastrointestinal
- ☐ Cirrhosis
- ☐ Digestive disorder
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Jaundice or Liver disease
- ☐ Reflux/heartburn
- ☐ Ulcer
- ☐ Other: ____________

Hematologic/ Lymphatic
- ☐ Anemia
- ☐ Bleeding disorders
- ☐ Clotting problems
- ☐ Sickle cell disease
- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising easily
- ☐ Swelling, warmth, or tenderness of veins or history of phlebitis
- ☐ Other: ____________

Genitourinary
- ☐ Enlarged prostate
- ☐ Frequent urinary tract infection
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Prostate enlargement
- ☐ Other: ____________

Pulmonary
- ☐ Allergies
- ☐ Asthma
- ☐ COPD/ Emphysema or chronic bronchitis
- ☐ Pneumonia
- ☐ Seasonal allergies
- ☐ Sleep apnea
- ☐ Snoring
- ☐ TB/Lung disease
- ☐ Pleurisy
- ☐ Chronic or frequent cough
- ☐ Shortness of breath
- ☐ Other: ____________

Neurologic
- ☐ Memory problems
- ☐ Numbness or tingling
- ☐ Seizures/ Epilepsy
- ☐ Glaucoma
- ☐ Frequent , recurring or increasing headaches
- ☐ Light-headedness or dizziness
- ☐ Tremors
- ☐ Paralysis
- ☐ Head injury
- ☐ Other: ____________

Childhood Illness
- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Whooping cough
- ☐ Other: ___________

Mental Health
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Nervousness
- ☐ Insomnia
- ☐ Memory loss/ confusion
- ☐ Claustrophobic
- ☐ Other: ____________

Other
- ☐ Cancer; type ___________
- ☐ Cataracts
- ☐ Frequent infection; type _______
- ☐ Auto Immune Disease
- ☐ Other: __________

Endocrine
- ☐ Diabetes or PreDiabetes
- ☐ Thyroid disease
- ☐ Osteoporosis
- ☐ Glandular or hormone
- ☐ Heat or cold intolerance
- ☐ Excessive skin dryness
- ☐ Excessive thirst or urination
- ☐ Change in hand or glove size
- ☐ Other: ____________

- ☐ _______________
- ☐ _______________
- ☐ _______________

SCANNING OF PAPER COPIES

In compliance with Iowa Law, Federal Law, and HIPAA, all medical records are maintained for at least 7 years. All paper records will be scanned and saved in their original form. The paper records will be destroyed once a quality scan is transferred and thoroughly backed up.

NOTICE OF PRIVACY PRACTICES

You may request to receive a copy of our Notice of Privacy Practices. You may request a paper copy, an electronic copy and you may also view this notice online, on our website at www.stadiasportsmedicine.com. I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

CONSENT FOR TREATMENT

I hereby authorize the physician/therapist at Stadia Sports Medicine to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

CANCELLATION POLICY

Unfortunately, we have frequently experienced patients cancelling with less than 24 hours' notice or not showing up for appointments. Therefore, we have found it necessary to institute a $50* cancellation fee. The purpose of this fee is to ensure that we can continue to provide our current level of service without having to reduce face-to-face time with the clinician.

If you must cancel or reschedule an appointment, we ask that you let us know at least 24 hours in advance. Appointments that are cancelled or rescheduled with less than 24 hours' notice are subject to the cancellation fee. This fee is billed directly to the patient. Insurance companies will not cover this fee. The patient will be held financially responsible for any cancellation fees that may be applied. We realize that occasionally emergencies do arise, so we will consider a one-time late cancellation with no fee incurred.

*We reserve the right to change this amount at any time without notice.

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and/or therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Stadia Sports Medicine all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Stadia Sports Medicine, will be credited to my account, in accordance with the above said assignment.

_______________________________________ _______________________

Signature of Patient or Guardian if patient is a minor Date