Stadia Sports Medicine **Patient Health Questionnaire**

Name: _____ **DOB:** _____ □ **M** □ **F** **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email address: _____ **Family Doctor:** _____

_____ initial I authorize Stadia Sports Medicine to contact me at the email address provided above.

Preferred phone: (_____) _____ □ Mobile □ Home □ Work
Secondary phone: (_____) _____ □ Mobile □ Home □ Work
Tertiary Phone: (_____) □ Mobile □ Home □ Work

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

_____ initial I authorize Stadia Sports Medicine to leave a message at the numbers listed above.

Language preference: □ English □ Spanish □ Other:

Race & Ethnicity □ Decline to share □ White □ White Hispanic/ Latino □ Other _____
□ American Indian, Alaskan Native □ Black, African American □ Black Hispanic/ Latino □ Unknown
□ Native Hawaiian, Pacific Islander □ Asian

Preferred Pharmacy: _____ **Pharmacy Address:** _____

Emergency Contact(s):
Name: _____ Phone number: (____) _____ Relationship: _____
Name: _____ Phone number: (____) _____ Relationship: _____

Referral Source: □ Physician/ Clinic Name _____ □ word of mouth/ family/ friend
□ Other _____ □ Google/web search □ Social Media/ FB/ Twitter, etc □ Insurance Company

Insurance Information & Authorizations

_____ initial I authorize my insurance to pay Stadia Sports Medicine PC directly for all medical charges. I also understand that this is a lifetime signature authorization. I 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 authorize the release of any information necessary to process my insurance.I understand that by utilizing my insurance, Stadia Sports Medicine PC cannot reduce my financial responsibility for charges applied to coinsurance, copayment, deductible or any other out of pocket amounts.

_____ initial I understand and acknowledge that it is my responsibility to understand the medical benefit provided by the insurance plan to which I subscribe. I am financially responsible for all services rendered by Stadia Sports Medicine PC and it's providers.

Insurance Subscriber Name: _____ **Date of Birth:** _____

Address: _____ _____ _____ _____
street address city state zip

Subscriber signature: _____ **Date:** _____

Release of Information, Privacy Practices, & Other

_____ initial If Stadia Sports Medicine PC is unable to reach me by phone, I authorize the release of my medical information to :
Name: _____ Phone: _____ Relationship: _____

_____ initial I authorize the release of any information acquired in the course of my examination or treatment to any other medical provider(s) involved in my case.
Primary Care/ Family Doctor: _____

_____ initial I understand there is a **cancellation policy** which requires 24 hours notice to appointment changes. 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.

_____ initial **NOTICE OF PRIVACY PRACTICES:** You may request to receive a copy of our Notice of Privacy Practices in the form of a paper copy, an electronic copy & you may view this notice online at www.stadiasportsmedicine.com. I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Scanning of paper copies: In compliance with Iowa law, Federal law, & HIPAA, medical records are maintained for at least 7 years. 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.

CONSENT FOR TREATMENT: I authorize the provider(s) at Stadia Sports Medicine to perform the treatments/procedures approved by my referring physician and/or myself. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

_____ Signature of Patient or Guardian if patient is a minor _____ Date

□ Pharmacy □ Referral info □ INS □ billing class □ Scanned □ Next of Kin □ New folder □ Tracking

Stadia Sports Medicine **Patient Health Questionnaire**

Reason for Visit I am to be seen for : _____ Onset:_____
Have you received any tests or treatments for this issue? □ No □ Yes, please explain: _____

Social History

Occupation: _____ for _____ years
Do you have children? □ No □ Yes, I have _____ (#) children.
Exercise:
Which kind(s) of exercise? _____
□ Never □ Weekly □ Other frequency
□ Rarely □ Daily _____times/_____

Smoking status: □ Never □ Former □ Current
#____ of _____/day for #____yrs.
(cigarettes, packs, etc)

Marital Status: □ Single □ Divorced □ Widowed □ Separated □ Married; spouse's name _____
_____ I authorize Stadia to discuss my health information with my spouse.
initial

Caffeine: *(check all that apply)* ___(#)/day
□ None □ Coffee □ Teas □ Sodas/Pop

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

Family Medical History

Relation & Age	Health Significant Illness	Age at Death	If deceased, cause & comments

Has any blood relative ever had? *(indicate relationship)*

□ Alcoholism _____ □ Heart attack before age 55
□ Allergies _____ □ Heart disease _____
□ Alzheimer's _____ □ High blood pressure _____
□ Asthma _____ □ High cholesterol _____
□ Bleeding disease _____ □ Mental disorder _____
□ Cancer :_____ _____ □ Seizures _____
□ Depression/Suicide _____ □ Stroke _____
□ Diabetes _____ □ Thyroid disease _____

Surgical & Other Medical History

Year	Surgery	Metal?
_____	_____	□
_____	_____	□
_____	_____	□
_____	_____	□

□ **Colonoscopy;** when _____

Medical Illnesses or Conditions

_____
_____
_____

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

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

Gastrointestinal
□ Cirrhosis
□ Digestive disorder
□ Diverticulitis
□ Hemorrhoids
□ Hepatitis
□ Hiatal hernia
□ Jaundice or Liver disease
□ Reflux/heartburn
□ Ulcer

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

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

Other
□ Cancer; type _____
□ Cataracts
□ Frequent infection; type ___
□ Auto Immune Disease
□ Other: _____

Genitourinary
□ Enlarged prostate
□ Frequent urinary tract infection
□ Kidney disease
□ Kidney stones

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

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

Mental Health
□ Anxiety
□ Bipolar disorder
□ Depression
□ Schizophrenia
□ Nervousness
□ Insomnia
□ Memory loss/ confusion
□ **Claustrophobic**

Childhood Illness
□ Chicken Pox
□ Measles
□ Mumps
□ Polio
□ Rheumatic Fever
□ Whooping cough

Allergies: (ex: latex, drugs, environmental)

_____
_____
_____

Medications, OTC, & Supplements

_____ _____
_____ _____
_____ _____

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