

Alexander Orthopaedic Associates

New Patient Information:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Please circle: M or F Race: \_\_\_\_\_ Language \_\_\_\_\_  
Ethnicity \_\_\_\_\_ Single Married Divorced Widowed  
Primary Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Secondary Home Address: - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

EMERGENCY CONTACTS:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
*If you have a spouse:*  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone # \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscribers SS#: \_\_\_\_\_ Subscribers DOB: \_\_\_\_\_  
Please Circle: **HMO PPO Other**

Secondary Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone # \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscribers SS#: \_\_\_\_\_ Subscribers DOB: \_\_\_\_\_  
Please Circle: **HMO PPO Other**

Did your injury occur at work? (Please circle) **Yes No** if yes, Date of injury \_\_\_\_\_  
Is your injury from an auto accident? (Please circle) **Yes No** if yes, Date of injury \_\_\_\_\_  
Are you being represented by an attorney? (Please circle) **Yes No**  
if yes, Name of attorney \_\_\_\_\_ Phone # \_\_\_\_\_

## MRI REFERRAL DISCLOSURE

In the course of your treatment, an x-ray, MRI, CT, bone scan, bone density scan, or other ancillary studies may be necessary and ordered. Alexander Medical Group, LLC, dba Alexander Orthopaedic Associates in accordance with the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, ("PPACA") Section 6003, informs you that it is your choice to have the study done at our facility or at the facility of your preference.

A written list of such facilities in the area is provided below.

<b>Advanced Medical Imaging</b>	<b>727-398-5999</b>	<b>Palms of Pasadena</b>	<b>727-341-7890</b>
<b>Bardmoor Imaging</b>	<b>727-461-8555</b>	<b>Pinellas High Field Imaging</b>	<b>727-347-4674</b>
<b>Central MRI</b>	<b>727-381-4674</b>	<b>Rose Radiology</b>	<b>727-531-5444</b>
<b>Largo Medical Center</b>	<b>727-588-5850</b>	<b>St. Petersburg General</b>	<b>727-341-4808</b>
<b>National PET Scan</b>	<b>727-471-1000</b>	<b>Tampa Bay Imaging (TBI)</b>	<b>727-545-9674</b>
<b>Gateway</b>	<b>727-525-2121</b>	<b>Westcoast Radiology</b>	<b>727-446-6760</b>

Please print and sign your name below to acknowledge your understanding of the above statements.

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Print Name

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Signature

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Date



ALEXANDER **ORTHOPAEDIC** ASSOC.

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## Alexander Orthopaedic Associates Disclosure of Policies

### **Financial Policy:**

Alexander Orthopaedic Associates participates with many forms of health insurance, such as HMO's, PPO's, Workman's Compensation and Medicare. However, few insurance carriers cover all medical costs and a balance on your account may result from co-payments, co-insurance, deductibles, or non-covered services. The patient is responsible for full payment of any and all balances deemed "patient responsibility" by their insurance carrier. We will file medical insurance claims as a courtesy to our patients.

**Motor Vehicle and Worker's Compensation:** In order for our office to submit your claims for you, you must provide us with the following information: insurance company name, address and telephone number, as well as your claim number, date of accident and claims adjuster's name. In the event that your insurance denies or terminates your benefits, you will be responsible for full payment for services rendered. Please note for all Workers' Compensation patients, your initial appointment must be scheduled by your nurse case manager or Worker's Compensation adjustor. Authorization must be received prior to the initial office visit. Motor Vehicle patients, please note prior to your initial office visit your auto benefits must be confirmed and verified by our office.

### **Payment Policy:**

All co-payments, co-insurance, and deductibles are paid at the time of service to help control costs of medical care. Payments may be made by cash, check, Visa, MasterCard, American Express, and Discover. For larger amounts, such as surgical fees not covered by insurance, AOA will work with you to arrange a payment plan. Self pay patients and Surgical Pre-pay patient's payments will only be accepted via credit card, cash payment, and/or money orders.

### **Treatment of Patients:**

Throughout your treatment at AOA, the medical providers may order diagnostic testing to help determine your diagnosis or create a better treatment plan for you, the patient. These tests include lab work, x-rays, MRI's, CT scans, Bone Scan's, etc. Failure to schedule or obtain the recommended diagnostic studies in a timely manner or to schedule a follow up appointment to review the diagnostic tests in a timely manner; will constitute as a breach of our recommendations and is Against Medical Advice (AMA). Therefore, AOA employees and medical providers will not be held responsible for lack of patient responsibility and purposeful disregard of our medical recommendations. Non-compliance may result in an adverse complication to the patient's medical result/ outcome.

Alexander Orthopaedic Associates notifies you that our providers may be involved in education, research, development and/ or consulting with regards to Orthopaedic products and the Orthopaedic industry; therefore the providers may benefit directly or indirectly from such educational, research, development and/ or consulting relationships. This will not conflict with the best interest of the patient and/or their medical condition/ diagnoses.

Alexander Orthopaedic Associates notifies you that some or all providers may or may not carry Medical Malpractice Insurance.

**AUTHORIZATION FOR  
RELEASE OF  
CONFIDENTIAL INFORMATION**  
(PURSUANT TO 45.C.F.R.164.508)  
(T) 727-547-4700 (F) 727-394-8661

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last 4 digits of Social Security Number: \_\_\_\_\_ MR#: \_\_\_\_\_  
Patient Phone Number: \_\_\_\_\_ (Personnel to Fill out)

I authorize to release **medical, psychiatric, alcohol and/or drug abuse, HIV testing, ARC and/or AIDS diagnosis, eating disorder information** or any other medical records of a sensitive nature:(Pursuant to 42.C.F.R.2.31)

**This will authorize:** \_\_\_\_\_ (Name of facility/entity to provide records)

**To Release To:**

**To Release To:**

Alexander Orthopaedic Associates  
12416 66<sup>th</sup> Street No Suite A  
Largo, FL. 33773

For the purpose of \_\_\_\_\_

Please disclose the exact information selected below:

**Entire Medical Record**, excluding \_\_\_\_\_

**Date(s) of Service:** \_\_\_\_\_

**Check all that apply:**

<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Medication Sheets	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Facesheet	<input type="checkbox"/> Pathology
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Emergency Report
<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG Report
<input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Consultations	<input type="checkbox"/> Other (Specify):

**Note: X-ray films must be obtained from Radiology Dept.**

**To be completed by the patient or personal representative:**

I hereby authorize the use or disclosure of my protected health information as described above.

This authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign the form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notifications to:

**Alexander Orthopaedic Associates 12416 66<sup>th</sup> Street No Suite A Largo, FL. 33773**

Any revocation will not affect disclosures made prior to Alexander Orthopaedic Associates receipt or knowledge of the revocation.

**I understand that I have a right to inspect and receive a copy of the information described on this form.**

Signature of patient or patient's representative/Power of Attorney \_\_\_\_\_

Printed name of patient's representative/Power of Attorney \_\_\_\_\_

Relationship to the patient:

Date: \_\_\_\_\_

Expiration Date of this Authorization: **One Year**

Alexander Orthopaedic Associates  
Patient Authorization Form

**HIPPA Privacy Notice**

I have received and read a copy of Alexander Orthopaedic Associates Notice of Privacy Practices (Notice).

*By initialing I have read and understand the above* \_\_\_\_\_

**Authorization to Release Information**

I consent to the use or disclosure of my protected health information by Alexander Orthopaedic Associates (AOA) for the purpose of diagnosing or providing treatment to me, obtaining payment for my Health care bills or to conduct health care operations of AOA. As mentioned in (sections I, II, III, V) of the Notice.

*By initialing I have read and understand the above* \_\_\_\_\_

**AOA Disclosures**

I acknowledge that I have been notified that some or all of the providers at AOA may or may not carry Medical Malpractice Insurance. I also acknowledge that I have been notified that the providers at AOA may be involved in education, research, development, and/ or consulting with regards to Orthopaedic products and the Orthopaedic industry; therefore, the providers may benefit directly or indirectly from such educational, research, development, and or consulting relationships. The above does not conflict with my best interest as a patient at AOA. I desire to enter into a doctor-patient relationship with a provider at AOA. As mentioned in (section VI) the Notice.

*By initialing I have read and understand the above* \_\_\_\_\_

**Financial Agreement & Payment Policy**

I understand that I am financially responsible for services rendered by AOA providers. I also understand that few insurance carriers cover all costs for services rendered. AOA will submit claims to your insurance carrier. I will be responsible for the balance on my account that my insurance company does not cover. I will pay any co-payments, co-insurance, and deductibles at the time of service at AOA. As mentioned in (section VII, VIII) in the Notice.

*By initialing I have read and understand the above* \_\_\_\_\_

**Authorization for treatment**

Throughout your treatment at AOA the medical providers may order diagnostic testing (lab work, bone scan's, x-rays, MRI's, CT scans... etc) that will help determine your diagnosis and future treatment. Failure to schedule or obtain the recommended diagnostic studies or failure to schedule a follow up visit in a timely manner to review the diagnostic studies and discuss the results will constitute as a breach of our recommendations. AOA employees and medical providers will not be held accountable for your lack of responsibility and purposeful disregard of our medical recommendations. As mentioned in (section IX) in the Notice.

*By initialing I have read and understand the above* \_\_\_\_\_

I hereby authorize the medical staff of AOA to render medical services and treatments as deemed necessary. I understand that failure to comply with our medical recommendations is against medical advice. (AMA)

*By initialing I have read and understand the above* \_\_\_\_\_

*By signing, I have read, understand and agree to comply with AOA policies so noted in the Notice of Privacy Practices (Notice).*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

*If patient is a minor (under 18):*

Minor's Name \_\_\_\_\_ Guardian's Name (printed) \_\_\_\_\_

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

# Consent for the Release of Protected Health Information to Personal Representatives

I, \_\_\_\_\_, give my written consent for Alexander Orthopaedic Associates to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

## Personal Representatives that Alexander Orthopaedic Associates may share my Protected Health Information with:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**\_\_\_\_\_ Do not discuss my Protected Health Information with anyone other than myself at any time.**

Alexander Orthopaedic Associates may leave a message:

At Home \_\_\_\_\_ At Work \_\_\_\_\_

Patients' Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Alexander Orthopaedic Associates**  
**Form Fee Agreement**

Please note: The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

NO Charge:

- Workers Compensation requested Disability and Work Status forms
- Auto Insurance Carrier requests for Work Status and Treatment Plans

\$15.00:

- Disabled Parking Applications

\$35.00/ form:

- Credit Card deferment forms
- Private Disability Insurance Forms
- School Educational Disability or Limitation Forms

\$35.00/form

- Family Medical Leave Act (FMLA) forms

\$150.00- \$300.00

- For completion of any dictated letter describing medical care and limitations
- For any narrative report detailing diagnosis, treatment, and future medical care including work capacity statements. Functional Capacity Evaluation testing may be necessary prior to, or in addition to the narrative report. The fee for the FCE test is determined by the facility that the testing is completed at.

*I have read and understand the above. By signing I agree to comply with the Form Fee policy of AOA. Fees subject to change without notice.*

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Patient Name (printed)

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Signature

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Date

# ALEXANDER ORTHOPAEDIC ASSOCIATES

## HISTORY & PHYSICAL

Room # \_\_\_\_\_  
Provider \_\_\_\_\_  
X-ray taken \_\_\_\_\_  
XR/MRI brought yes no  
Facility \_\_\_\_\_  
(for office use only)

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

(please circle): **M** **F** Right handed Left handed **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **BLOOD PRESSURE:** \_\_\_\_\_

**RACE/ETHNICITY** (please circle): **WHITE** **HISPANIC** **AFRICAN AMERICAN** **PACIFIC ISLANDER** **OTHER** \_\_\_\_\_

**PRIMARY CARE** \_\_\_\_\_

**PREFERRED LANGUAGE** (please circle): **ENGLISH** **SPANISH** **OTHER** \_\_\_\_\_

**TODAYS CHIEF COMPLAINT** (what body part are you seeking treatment for) \_\_\_\_\_  right  left

**HISTORY OF PRESENT ILLNESS OR INJURY** (when and how did it happen):

**EXACT DATE PAIN BEGAN OR INJURY OCCURRED** \_\_\_\_\_

**HOW WERE YOU INJURED?**  IN A SPORT  ACCIDENT  AUTO ACCIDENT  NEITHER

**WERE YOU INJURED AT WORK?**  YES  NO **IF YES, WHAT DATE WERE YOU INJURED?** \_\_\_\_\_

**HOW LONG HAVE YOUR SYMPTOMS BEEN PRESENT?** \_\_\_\_\_

**ON A SCALE OF 1-10, HOW SEVERE IS YOUR PAIN?** \_\_\_\_\_

**WHAT MAKES YOUR SYMPTOMS WORSE?** \_\_\_\_\_

**WHAT MAKES YOUR SYMPTOMS BETTER?** \_\_\_\_\_

**PREVIOUS INJURY TO THIS AREA:** (please circle) **Y** **N**

If yes, explain:

**CURRENT MEDICATIONS** (name, strength and dose):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_

**PAST MEDICAL HISTORY:** (please check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Hepatitis A, B, or C   | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Bleeding Disorders/Blood Clots | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Renal Disease        |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> COPD                           | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> GERD                           | <input type="checkbox"/> Neurological Disorders |   |
| <input type="checkbox"/> GI Disorders                   | <input type="checkbox"/> Other                  |   |



PATIENT NAME: \_\_\_\_\_

ALLERGIES (please circle): Aspirin Codeine Latex Penicillin Sulfa None Other: \_\_\_\_\_

Reaction: \_\_\_\_\_

LIST ALL PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES:  NONE

1. \_\_\_\_\_ YEAR \_\_\_\_\_
2. \_\_\_\_\_ YEAR \_\_\_\_\_
3. \_\_\_\_\_ YEAR \_\_\_\_\_
4. \_\_\_\_\_ YEAR \_\_\_\_\_
5. \_\_\_\_\_ YEAR \_\_\_\_\_

### FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, list your relative

- Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Rheumatoid Arthritis \_\_\_\_\_  
Difficulty with anesthesia \_\_\_\_\_ Bleeding Problems \_\_\_\_\_ None known

SOCIAL HISTORY (please circle): Smoking Qty \_\_\_\_\_ Drinking Qty \_\_\_\_\_ Drugs Type/Qty \_\_\_\_\_

MARITAL STATUS (please circle): Single Married Divorced Widow Separated Student

EMPLOYMENT STATUS (please circle): Employed Unemployed Disabled Retired Occupation \_\_\_\_\_

### REVIEW OF SYSTEMS

Have you ever had any of these symptoms? If no, mark NONE

NONE YEAR Details/Comments

- |                             |  |  |   |                          |       |       |
|-----------------------------|--|--|---|--------------------------|-------|-------|
| 1. GI                       | <input type="checkbox"/> Heartburn, Ulcers               | <input type="checkbox"/> Nausea, Vomiting                | <input type="checkbox"/> Blood in Stool                             | <input type="checkbox"/> | _____ | _____ |
| 2. ENDO                     | <input type="checkbox"/> Thyroid Disease                 | <input type="checkbox"/> Heat or Cold Intolerance        |   | <input type="checkbox"/> | _____ | _____ |
| 3. CON                      | <input type="checkbox"/> Weight Loss                     | <input type="checkbox"/> Loss of Appetite                | <input type="checkbox"/> Fatigue                                    | <input type="checkbox"/> | _____ | _____ |
| 4. EYE                      | <input type="checkbox"/> Blurred Vision                  | <input type="checkbox"/> Double Vision                   | <input type="checkbox"/> Vision Loss                                | <input type="checkbox"/> | _____ | _____ |
| 5. ENT                      | <input type="checkbox"/> Hearing Loss                    | <input type="checkbox"/> Hoarseness                      | <input type="checkbox"/> Trouble Swallowing                         | <input type="checkbox"/> | _____ | _____ |
| 6. CV                       | <input type="checkbox"/> Chest Pain                      | <input type="checkbox"/> Palpitations                    |   | <input type="checkbox"/> | _____ | _____ |
| 7. RS                       | <input type="checkbox"/> Chronic Cough                   | <input type="checkbox"/> Pneumonia                       | <input type="checkbox"/> Shortness of Breath                        | <input type="checkbox"/> | _____ | _____ |
| 8. GU                       | <input type="checkbox"/> Painful Urination               | <input type="checkbox"/> Blood in Urine                  | <input type="checkbox"/> Kidney Problems                            | <input type="checkbox"/> | _____ | _____ |
| 9. SK                       | <input type="checkbox"/> Frequent Rashes                 | <input type="checkbox"/> Skin Ulcers                     | <input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis   | <input type="checkbox"/> | _____ | _____ |
| 10. NEU                     | <input type="checkbox"/> Headaches                       | <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness | <input type="checkbox"/> | _____ | _____ |
| 11. PSY                     | <input type="checkbox"/> Depression/Anxiety              | <input type="checkbox"/> Drug/Alcohol Addiction          | <input type="checkbox"/> Sleep Disorder                             | <input type="checkbox"/> | _____ | _____ |
| 12. HEM                     | <input type="checkbox"/> Easy Bleeding                   | <input type="checkbox"/> Easy Bruising                   | <input type="checkbox"/> Anemia                                     | <input type="checkbox"/> | _____ | _____ |
| 13. Are you HIV Positive?   |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |                          |       |       |
|                             | Have you ever had Hepatitis A, B, or C?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes what type? _____   |                          |       |       |
| 14. Are you pregnant?       | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |                          |       |       |
| 15. Are you Claustrophobic? | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |                          |       |       |

PHARMACY NAME \_\_\_\_\_  
 ADDRESS/CROSS STREETS \_\_\_\_\_  
 PHONE# \_\_\_\_\_

## Patient Assessment

The physicians at Alexander Orthopaedic Associates are concerned about your orthopaedic health and want to make sure that we are evaluating those factors which may impact your orthopaedic wellbeing. The following questions are intended to give the physicians at Alexander Orthopaedic Associates information about your general health.

Please circle the correct answer or fill in the blanks.

1. What is your height \_\_\_\_\_ weight \_\_\_\_\_ Prefer not to answer \_\_\_\_\_
2. Have you had a Bone Density Study (also known as a Dexa scan) for osteoporosis at least once since age 60?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, in what year did you have the most recent Bone Density Study? \_\_\_\_\_
3. Have you been on medicine to treat osteoporosis? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, has it been prescribed within 12 months? Yes \_\_\_\_\_ No \_\_\_\_\_  
What medicine are you taking to treat your osteoporosis? \_\_\_\_\_
4. Do you take Calcium and Vitamin D? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Have you ever had a fracture of your arm, hip, or spine? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Have you fallen more than twice or fallen and hurt yourself in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Have you had the influenza vaccination for the current flu season? Yes \_\_\_\_\_ No \_\_\_\_\_
8. Have you ever had the pneumococcal vaccine? Yes \_\_\_\_\_ No \_\_\_\_\_
9. Do you have an Advanced Care Plan? Yes \_\_\_\_\_ No \_\_\_\_\_
10. Have you used or smoked tobacco products in the last 24 months? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, are you a tobacco smoker? Yes \_\_\_\_\_ No \_\_\_\_\_
11. Do you consume alcoholic beverages? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how much per setting? \_\_\_\_\_ Per week? \_\_\_\_\_

Please understand that smoking and consuming alcoholic beverages can impair your general health as well as your orthopaedic health.

Are you interested in quitting? Yes \_\_\_\_\_ No \_\_\_\_\_

Print name: \_\_\_\_\_

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_