



Patient name \_\_\_\_\_

**Past Medical History Form**

**Note: This is a confidential record of your medical history. It will be entered into your electronic medical record in our office. This information will not be released to anyone without your authorization.**

Who referred you to our office or how did you find us? \_\_\_\_\_

**Past Medical History**

Present complaint/ problem that you need help with: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

What **medical problems, diagnoses, chronic diseases** do have?

\_\_\_\_\_  
\_\_\_\_\_

**Surgeries:** List any surgeries and give approximate dates \_\_\_\_\_

\_\_\_\_\_

Have you ever been advised to have a surgical procedure that has not been done? \_\_\_\_\_

\_\_\_\_\_

**Injuries:** List any broken bones or other serious injury and give approx. dates \_\_\_\_\_

\_\_\_\_\_

**Infections:** please circle if you've had chicken pox, measles, mumps, whooping cough, rheumatic fever, scarlet fever, tuberculosis exposure, other \_\_\_\_\_

\_\_\_\_\_

**Medications:** List all you currently take: \_\_\_\_\_

\_\_\_\_\_

**Allergies:** Please list all known allergies \_\_\_\_\_

\_\_\_\_\_

What type of allergic reaction do you have to each of the above mentioned items?

\_\_\_\_\_

\_\_\_\_\_

## Review of Symptoms

Please **Circle** any of the following problems or symptoms which you may have:

**General Health:** weakness, fatigue, body aches, headaches, poor appetite, excessive appetite,

Other \_\_\_\_\_

**Skin:** hives, eczema, dryness, itching, rash, changes in moles or skin color, changes in nails

Other \_\_\_\_\_

**Head:** headaches, migraines, fainting/loss of consciousness, dizziness, passing out

Other \_\_\_\_\_

**Eyes:** blurred vision, double vision, change in vision, pain,

Other \_\_\_\_\_

**Ears:** changes in hearing, pain, ringing, drainage, vertigo

Other \_\_\_\_\_

**Nose:** congestion, runny nose, bloody nose, pain, sinus problems, snoring

Other \_\_\_\_\_

**Throat and Mouth:** Frequent sore throat or hoarseness, bleeding gums, pain or difficulty swallowing, dry mouth, sores in mouth, jaw pain, difficulty opening mouth

Other \_\_\_\_\_

**Lungs:** shortness of breath, wheezing, asthma, cough, coughing blood, painful breathing

Other \_\_\_\_\_

**Heart and blood vessels:** palpitations/fluttering, irregular beat, decreased exercise tolerance, high blood pressure, heart attack, chest pain, swelling in legs, cold or discolored hands or feet, spider or varicose veins, anemia

Other \_\_\_\_\_

**Gastro-Intestinal:** abdominal pain, constipation, diarrhea, nausea, vomiting, ulcers, heartburn/indigestion, gall bladder disease, changes in bowel habits, excessive gas, colitis, bloating, dark tarry stools, hemorrhoids

Other \_\_\_\_\_

**Genito-Urinary:** frequency, urgency, difficulty starting stream, incomplete emptying, painful urination, changes in bladder function

Other \_\_\_\_\_

**Muscles, Bones and Joints:** muscle or joint pain, stiffness, muscle cramps, muscle weakness, joint swelling, fracture, redness, restricted joint motion, arthritis, pain or cramps with exercise, bursitis, fracture, thinning bones,

Specific Joint problems: shoulder, elbow, wrist, hand, fingers, hip, knee, ankle, foot, toes

Other \_\_\_\_\_

**Back and Neck:** back pain or stiffness, neck pain or stiffness, restricted motion, disc problems, sciatica, fracture

Other \_\_\_\_\_

**Nerves:** numbness or tingling, limb weakness, shaking or tremors, neuralgia, memory loss,

Other \_\_\_\_\_

**Endocrine or glands:** swollen glands, heat or cold intolerance, appetite change, excessive thirst, change in skin texture, hair loss or excessive growth, change in menstrual cycle, excessive urination, hot flushes, thyroid problems, immune problems

Other \_\_\_\_\_

**Psychiatric and Mood:** depression, anxiousness, poor energy or motivation, short temper, compulsive behavior, change in mood, problems sleeping, poor concentration,

Other \_\_\_\_\_

Other condition or problem not listed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient name \_\_\_\_\_

### Social History

Marital Status:  Single  Married  Divorced  Separated  Domestic Partnership

Have you ever been treated for, or feel you have a problems with, alcoholism or any substance abuse?

No  Yes: \_\_\_\_\_

Do you smoke?  No  Yes \_\_\_\_\_ packs per day  less than a pack a day  about a pack a week

Do you drink?  No  Yes \_\_\_\_\_ drink(s) per day  social occasions  rarely  moderately

What kind of work do you do? \_\_\_\_\_

What types of recreational/relaxation activities do you participate in? \_\_\_\_\_

How often? \_\_\_\_\_

### Family Health History

Family History	If Living		If Deceased		Has any blood relative had:	Please check yes or no.	
	Age	Health	Age at death	Cause		Yes	No
Father					Cancer		
Mother					Tuberculosis		
Brother					Diabetes		
Sister					Heart Trouble		
Sibling					High Blood Pressure		
Sibling					Stroke		
Son or daughter					Arthritis		
Son or daughter					Allergic diseases		
					Nervous or mental diseases		
					Headaches		
					Other		

### Women Only

Menstruation History: Age at onset \_\_\_\_\_ Regular?  Yes  No Pain or cramps?  Yes  No  
 Date of last period: \_\_\_\_\_ Change in cycle?  Yes  No Painful intercourse?  Yes  No  
 Do you take birth control?  Yes  No How many children do you have? \_\_\_\_\_

**Do you have any concerns you would like to have addressed?**

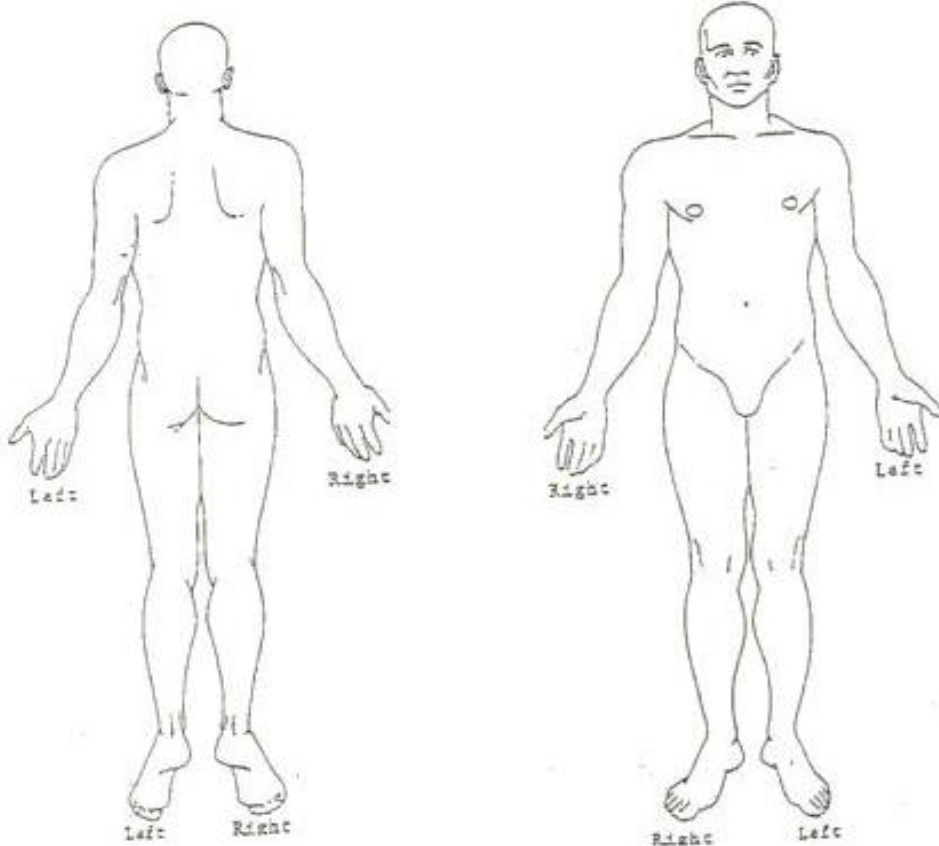
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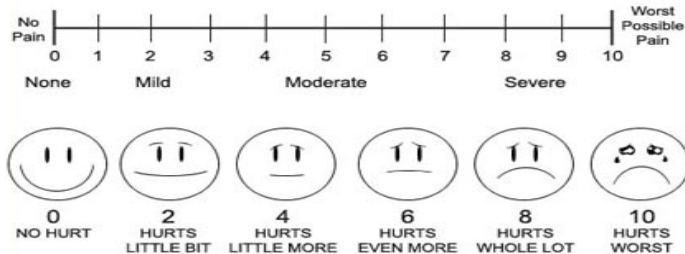
**Pain Diagram and Pain Scale**

Please mark on this diagram all the areas that you are having pain.



If you have more than 1 type of pain that you would like us to know about, please use the following key:

Aching: =====    Tingling, pins or needles: 0000    Burning: XXXX    Sharp or stabbing: //// ||



Please put an 'A' on the scale above to indicate your average pain on a typical day, and put a 'W' to indicate the level of your worst pain.



Patient name \_\_\_\_\_

**AGREEMENT FOR CONTROLLED SUBSTANCES**

We want to help you restore function and help control your pain. To achieve those goals this office is willing to prescribe controlled substances. Controlled substance medications (i.e., narcotics, opiates, sedatives, and barbiturates) can be very useful, but have a significant potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain and to improve both function and ability to work. Because this office assumes additional risk by our willingness to prescribe these medications, we ask that you read and agree to the following conditions. Signing this agreement does **NOT** indicate that you want these medications nor that we will necessarily prescribe them for you.

*If I checked this box, I do not want controlled prescriptions. However, if I ever get controlled medications I agree to these provisions.*

- \_\_\_\_\_ 1. I am responsible for my controlled medications. If the medications are lost, misplaced, or stolen, **REGARDLESS OF THE REASON,** I understand they **WILL NOT** be replaced.
- \_\_\_\_\_ 2. I **WILL NOT** request nor accept medications from any other physician or individual while I'm receiving medications from Dr. Radnovich. Besides being illegal to do so, it may endanger my health. The only exceptions are medications I am already taking THAT I HAVE TOLD Dr. RADNOVICH ABOUT; or medications prescribed while I am admitted to a hospital or being seen by one of Dr. Radnovich's associates in the clinic under his supervision.
- \_\_\_\_\_ 3 Refills of controlled medications:
  - a. Will be made only during **regular office hours**, in person, at least once a month, during a scheduled office visit.
  - b. **Will not** be made if I "run out early", I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
  - c. I will call **at least** 24 hours but **no more than 48 hours** before my medications will run out, to arrange for refills.
- \_\_\_\_\_ 4. I **WILL NOT** discard, flush down the toilet, give away or in any way loose control of medications, **INCLUDING MEDICATIONS THAT I NO LONGER USE.** I will bring in all the medications in their original containers (including the unused portions) each office visit, even if there is no medication remaining.
- \_\_\_\_\_ 5. I **WILL NOT** give, sell or in any manner allow anyone to use medications prescribed for me. Besides being illegal to do so, it may endanger health of those taking my medications.
- \_\_\_\_\_ 6. I **WILL TAKE** the medications as prescribed. Improper use can cause death. It is my responsibility to inform Dr. Radnovich about the success or failure of treatment so he can make appropriate adjustments in my medications.
- \_\_\_\_\_ 7. I understand that the main treatment goal is to improve my ability to function and/or work, not simply to reduce pain. I agree to help myself by following better health habits like regular exercise, weight loss as recommended, and not using tobacco or alcohol. I understand that following a healthier lifestyle will help me reduce my pain and improve function.
- \_\_\_\_\_ 8. I will not use any illicit drugs, as defined by law. These include marijuana, heroin, methamphetamine, cocaine, PCP and hallucinogens
- \_\_\_\_\_ 9. I will not drive or use machinery or dangerous equipment if I am feeling tired or impaired, or if I have been told that I am impaired.
- \_\_\_\_\_ 10. In order for Dr. Radnovich to monitor my compliance with proper medication use, I agree to drug testing. I also waive certain privacy rights, including talking with other health care providers, family members and, if necessary, law enforcement officials. In addition, I will come into the office when asked for testing and to produce unused portions of medications to verify they are being taken as directed.
- \_\_\_\_\_ 11. I have been fully informed by Dr. Radnovich and/or his staff regarding psychological and physical dependence to controlled substances. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same level of pain control. I also know that I may become physically dependent of the medication and stopping the medications suddenly may cause serious withdrawal symptoms.
- \_\_\_\_\_ 12. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment with Dr. Radnovich may be immediately terminated and I risk experiencing withdrawal symptoms. If the violation involves obtaining or giving someone controlled substances, I may also be reported to my other healthcare providers, medical facilities, and law enforcement officials.
- \_\_\_\_\_ 13. I have read this agreement. It has been explained to me by Dr. Radnovich and/or his staff. I fully understand the consequences of violating this agreement.
- \_\_\_\_\_ 14. I am taking these medications to control my severe pain, which has not responded to lesser medications.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness initial \_\_\_\_\_



Patient name \_\_\_\_\_

**Notice of Privacy Practices for Injury Care Medical Center**

**This document describes how your health information may be used or given to others. It also explains how to access this information. Please review it carefully; you may request a copy of this document at any time.**

**Typical Uses and Disclosures of Health Information**

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established privacy practices to assure non-essential persons do not view your information.

**Disclosure:** We may disclose your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy also. Information may also be shared with your family, friends and/or other persons you choose to have involved in your care, only if you agree that we may do so. If you wish to restrict information, please let us know in writing: 1) the information you wish to have restricted 2) whom you want the limits applied to.

**Payment:** We may use and disclose your health information to seek payment for services we provide you. This may include our business office staff and insurance companies, or other businesses involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of emergency involving your care, your location, your general condition or death. You may designate an emergency contact and we will use our professional judgment to determine which information will be disclosed. We will also use or professional judgment to make reasonable inference of your best interest by allowing your designee to pick up prescriptions, x-rays or other similar forms of health information or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, database managers, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We will disclose your healthcare information where required by law, court or administrative orders, subpoena, discovery request, or other lawful process. Also, for the use as requested lawfully by national security, intelligence and other State and Federal officials, and/or if you are an inmate.

**Abuse or neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes, or if you are homicidal or suicidal. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your healthcare information to report problems with products, reactions to medications, product recalls, disease or infection exposure and to prevent and control disease, injury or disability.

**Marketing/Research:** We will not use your health information for marketing or research purposes without your written authorization to do so.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards or letters.

**Access:** You may inspect and receive copies of your health information, or that of an individual for whom you are a legal guardian. There may be a small fee for copies and postage and we may request you make an appointment to review your chart. If you wish any of your health information to be amended, you must submit your request in writing with an explanation of why you feel it should be changed. Under certain circumstances, your request may be denied.

**Complaints:** You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us.

**How to contact us:** Injury Care Medical Center, 4850 N. Rosepoint Way, Ste. 100, Boise, ID 83713. Telephone: 208-939-2100.

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