Michael W. Higgins, DO, FAOAO, P.A.

PATIENT UPDATE

Date: _____

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Marital Status: _____

Phone #: Cell: _____ Home: _____

DOB: _____

Did you have a change in Insurance Coverage? YES or NO

Insurance Company: _____

Policy Number: _____

Group Number: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Location: _____

4055 Mariner Blvd., Spring Hill, FL 34609
Phone (352) 688-6035 Fax: (352) 688-6219 WWW.HernandoOrthoSpine.com

What is your current occupation? _____

If you stopped working, on what date did you stop? _____

Have you changed jobs because of your present problem/injury? Yes No

Is an attorney involved with this injury/problem? Yes No

Are you on Social Security, Disability or Worker's Compensation? Yes No

MEDICAL HISTORY:

The following is a list of common health problems.

PROBLEM	DO YOU HAVE THIS PROBLEM?		DO YOU RECEIVE TREATMENT FOR IT?	
Heart Disease	YES	NO	YES	NO
Chest Pain	YES	NO	YES	NO
High Blood Pressure	YES	NO	YES	NO
Stroke/TIA	YES	NO	YES	NO
Cancer	YES	NO	YES	NO
Brain or Spinal Cord problem	YES	NO	YES	NO
Depression	YES	NO	YES	NO
Psychiatric Problems	YES	NO	YES	NO
Alzheimer's Disease	YES	NO	YES	NO
Eye problems	YES	NO	YES	NO
Bladder problems	YES	NO	YES	NO
Prostate problems	YES	NO	YES	NO
Kidney Problems	YES	NO	YES	NO
Anemia	YES	NO	YES	NO
Blood disorder	YES	NO	YES	NO
Sickle cell anemia	YES	NO	YES	NO
Diabetes.	YES	NO	YES	NO
Thyroid disorder	YES	NO	YES	NO
Skin rashes	YES	NO	YES	NO
Psoriasis	YES	NO	YES	NO
Osteoporosis	YES	NO	YES	NO
Gout	YES	NO	YES	NO
Osteoarthritis	YES	NO	YES	NO
Rheumatoid Arthritis	YES	NO	YES	NO
High Cholesterol	YES	NO	YES	NO
Numbness in Fingers	YES	NO	YES	NO
Reflux disease	YES	NO	YES	NO
Hiatial hernia	YES	NO	YES	NO
Liver disorder	YES	NO	YES	NO
Stomach disorder/ulcers	YES	NO	YES	NO
Asthma/Breathing problems	YES	NO	YES	NO
Emphysema/COPD	YES	NO	YES	NO
Blood clot in leg	YES	NO	YES	NO

Pulmonary Embolus	YES	NO	YES	NO
Take blood thinners	YES	NO	YES	NO
Take steroid medications	YES	NO	YES	NO
Fever	YES	NO	YES	NO
Weight Loss	YES	NO	YES	NO
Appetite Loss	YES	NO	YES	NO
Frequent Falls	YES	NO	YES	NO
Ear/hearing problems	YES	NO	YES	NO

What are your current medications?

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

List any medications that you are allergic to:

_____ reaction: _____

_____ reaction: _____

_____ reaction: _____

List all surgical procedures:

_____ year: _____

_____ year: _____

_____ year: _____

_____ year: _____

_____ year: _____

_____ year: _____

_____ year: _____

Have you had problems with anesthetics? YES NO

Do you smoke? YES NO

If yes, how many packs a day? _____ pack(s)

What is your current marital status? _____

Do you live with someone that can take care of you? YES NO

Hernando Orthopaedic & Spinals Surgery

Michael W. Higgins. D.O., P.A.

Authorization to Release Medical Records & or Information to assigned person(s).

This authorization allows Hernando Orthopaedic & Spinal Surgery and Dr. Higgins and staff to release medical information to a person (named below) involved in the patient's medicale care. Other than the named person or you, we will not discuss anything related to your care with anyone if they are not listed in this release. The only exception.is other medical professionals and their offices/facilities as necessary to provide you with medical care and your Insurance company as outlined in our privacy notice. If you wish family members or caretakers to have information about your care, you must fill out this form.

Patient's Name: _____

Social Security #: _____ D.O B.: _____

Person(s) with whom you would like your medical history, test results, appointments, etc. discussed (example: spouse, children or friend):

1) Name: _____ Phone: _____
Relationship: _____ D.O.B.: _____

2) Name: _____ Phone: _____
Relationship: _____ D.O.B.: _____

Please sign this section to acknowledge and validate this form.

Patient's Name (Please Print) Or Legal Guardian/Power of Attorney (Please Print)

_____ _____

_____ _____

Patient's Signature Legal Guardian / PPOA's Signature

**Hernando Orthopaedic & Spinal Surgery will call to confirm your office visit 1-2 days prior to the appointment. May this information or other confirmation be left on your answering machine? No test/lab results or specific medical information messages will ever be left.

_____ YES _____ NO Initial: _____

Or if you do NOT want any family members or friends to know about your care:

_____ I would not like my care discussed with anyone other than medical professionals and offices/facilities as necessary to provide care for me.

Revocation Section-Desire to Terminate this Agreement: I understand that I may revoke this authorization at any time by notifying Hernando Orthopaedic & Spinal Surgery in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Effective: _____date, the authorization is no longer valid.

_____ _____

Patient's Signature Legal Guardian / PPOA's Signature