MEDICAL HISTORY FORM

Bubble the cirlcle which best describes how your problem started. Please answer the questions related to the box you checked.
Marque la casilla que mejor describa como comenzo su problema.Porfavor conteste las preguntas relacionada con el cuadro quemarco

Patient Name: ______________________________ **Date of Birth:** ____________________
Nombre Fecha de nacimiento
Age: ________ **Sex:** Male Female **Height:** ________ **Weight:** ________
Edad Sexo Masculio Feminino Estatura Peso
Referring Physicians Name: ______________________________
Medico que lo refirio
Pharmacy: __________________**Location:** ____________________**Phone #:** __________
La pharmacia Ubicacion Telefono de pharmacia
Dominant Hand **Right** **Left**
Mano Dominante Derecha Izquierda
Reason for Visit (chief complaint) ______________________________
Razon por vista
Previous Injury to affected body part **Yes** **No**
A tenido lecion previa para el mismo parte del cuerpo: Si No
If Yes, explain (Si si, expique):______________________________

NO INJURY Was the onset Gradual Sudden **NO LESIONES** **Fue el comienzo** **Gradual** **Rapentino** Onset Date: (Fecha)__________________ **INJURY** Accident Sport **LESIONES** **Accidente** **Deportes** Date: Fecha)__________________ **INJURY AT WORK** Date: __________________ ACCIDENTE DE TRABAJO Fecha **AUTO ACCIDENT** Date: __________________ ACCIDENTE DE AUTO Fecha	**Description of Injury / Accident** DESCRIPCION DE LA LESION / ACCIDENTE ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________

Have you had a problem like this before? Y N
Ha tiendo un problema como esta antes? Si No
Were you seen in the E.R. for this problem? Y N Which E.R.? ____________________
Ha estado en sala de Emergencia por esta problema? Si No Que Hospital?
What test scans have you had for this problem? Que estudios le han hecho?
X-rays MRI CAT Scan Bone Scan Nerve Test (EMG / NCV)
On a scale of 0-10 (10 is the worst) how severe is your pain?
En una escala de 0-10 (10 es el peor) cual es la gravedada de su dolor?
0 1 2 3 4 5 6 7 8 9 10
What is the quality of pain? Sharp Dull Stabbing Throbbing Aching Burning
Como es su dolor? Agudo Tolerable Pinchazo Puzante Inflamado Ardiente
The pain is Constant Intermittent (comes & goes) **Does the pain wake you from your sleep?** Y N
El dolor es Constante Inetermitente (viene y va) El dolor lo desperita de noche? Si No
I experience: Swelling Bruising Numbness Tingling Weakness
Yo siento: Hinchazon Morentones Entumecimiento Hormigueo Debilidad
Loss of control of bowel or bladder Locking / Catching Giving way Pain Stiffness
Perdida del control del intestino o de la vejiga Bloqueo Inestablididad Dolor Rigidez
Since my problem started, it is: Getting Better Getting worse Unchanged
Desde que comenzo mi problema, me siento: Cada vez mejor Cada vez peor Sin Cambios
What makes your symptoms worse: Standing Walking Lifting Twisting Bending Stairs
Que hace sus sintomas emperoren: Estar de pie Caminar Levantar Torcer Doblar Subir O bajar
Exercise Squatting Kneeling Sitting Coughing Sneezing
Ejercicios Cuclicilias Arrodillarse Sengtarse Torser Estornudar
What makes your symptoms better?: Rest Elevation Ice Heat
Que hace que sus sintomas mejoren? Descansar Elvar Hielo Calor

Copyright © 2011 Exscribe, Inc. All rights reserved.

Patient Name: ______________________________________

SURGICAL HISTORY
HISTORAL DE CIRUGIA

Please check any previous surgical procedures, list the date and describe the surgery:
Marque si a tenido cirugia previamente:

Appendectomy / Appendictomia
Hernia / Hernia
Arthorscopy, lower extrmity / Artroscopia de Cadera, rodilla, tobillo
Arthroscopy, upper extremity / Artoscopia de hombro, codo, muneca
Spine/ Back / Espalda/columna
Heart / Corazon
Total joint replacement / Reemplazo de articulation
Fracture repair / Reparo de fractura
None / No
Bone Fracture / Fractura de hueso
Other:____________________ / Otro

SOCIAL HISTORY
HISTORIAL SOCIAL

Tobacco Use **Yes** **No** **Type:** ________________ **Duration: Quit Date:** ____________________
Uso de tabaddo Si No Tipo: Frecuencia:

Alcohol use: **Yes** **No** **Frequncy:** ____________________
Uso de alcol: Si No Frecuencia:

Drug Use: **Yes** **No** **Frequncy:** ____________________
Uso de droga: Si No Frecuencia:

Marital History: **Married** **Single** **Divorced** **Widowed**
Estado civil Casado Soltero Divorciado Viudo

Are you currently working? Y N Retired Disabled If no, when did you last work? ________________
Esta travajando actualmente? Si No Jubilado Discapacitado Si no, cuando ultimo trabajo?

Are you currently on any work restrictions? Y N If yes, what are they?
Esta usted actualmente bajos restrictiones de trabajo? Si No En caso afirmativo, cuales son?

Occupation: Employer: ________________________ Student
Empleador Alumno

MEDICAL HISTORY

Anemia
D epression / Depresion
Hepatitis A or B / Hepatitis A o B
Osteoporosis
Arthritis / Artritis
Diabetes
High Blood Pressure / Presion Alta
Rheumatoid Arthritis / Artritis Reumatoides
Asthma / Asma
Emphysema / Enfisema
HIV/AIDS / SIDA
Stroke/ Seizure / Derrame/ataques
Blood Clots / Cuavulo de sangre
Heart Disease / Problemas cardiacos
Irregular Heartbeat / Latidos iregulares
Thyroid / Tiroide
Cancer
Liver Disease / Problemasde higado
Chemical Dependancy/alcoholism / Dependincia quimica/alcolismo
Stomach problems-explain: ______________________ / Problemas estomacales-explique:

Other: ____

Are you allergic to any medications? Y N____
Es alergico a esta medicinas? Si No

MEDICATIONS (MEDICAMENTOS) **NONE (NO)**

Please list: **Dosage (required)**
Lista de medicinas: **Dosis (require)**

____________________________mg _____ ____________________________mg _____
____________________________mg _____ ____________________________mg _____
____________________________mg _____ ____________________________mg _____
____________________________mg _____ ____________________________mg _____
____________________________mg _____ ____________________________mg _____

FAMILY HISTORY

Please check family history conditions
Marque condiciones en su familia:

None / No
Blood Clots / Cuavluos de sangre
Diabetes
Hypertension / Presion Alta
Rheumatoid Arthritis / Artritis Reumatoides
Cancer
Heart Disease / Problemas de Corazon
Osteoporosis
Stroke/ Seizures / Derrame/attaques

Copyright © 2011 Exscribe, Inc. All rights reserved.

Patient Name: ____

REVIEW OF SYSTEMS

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

Marque condiciones correinto o previa. Si no tiene condicion profavor marque no.

					NONE / NO	OTHER / OTRO
1) CON	Weight Loss Perdida de Peso	Weight Gain Aumento de Peso	Insomnia	Chronic Fatigue Fatiga chronica		______
2) EYE	Vision Changes Cambio de vision	Glasses/ Contacts Anteojos/ contacts	Cataracts Catarata	Glaucoma		______
3) ENT	Hearing Loss Perdid de oir	Seasonal Allergies Alergias del tiempo	Sinus Pain Sinusitis	Ringing Timbrar		______
4) CV	Chest Pain Dolor de pecho	Edema	Hypertnesion Hipertension	Palpitations Palipataciones		______
5) RS	Asthma Asma	Wheezing Respolido	Frequent Cough Tos Frecuente			______
6) GI	Heartburn Acidez	Indigestion	Acid Reflux Reflujo Acido	Ulcer Problems Ulceras		______
7) MUSC	Arthritis Artiritis	Muscle Weakness Debilidad muscular	Joint Pain Dolor de articulacion	Back Pain Dolor de espalda		______
8) SK	Rash Salullido	Skin Ulcers Ulceras	Scars Cicatriz			______
9) NEU	Headaches Dolor de cabeza	Dizziness Mareo	Seizures Ataques	Numbness Entumecimiento		______
10) PSY	Depression Depresion	Crying Llorar	Anxiety Ansiedad	Mood Swings Cambio de humor		______
11) ENDO	Diabetes	Hypothyroid Tiroide Baja	Hyperthyroid Hiroide Alta			______
12) PSY	Easy Bleeding Moretones	Easy Bruising Sanframiento	Anemia			______

____ ____________

Signature **Date**

Copyright © 2011 Exscribe, Inc. All rights reserved.

Patient Registration
(Registracion Del Paciente)

First Name: ________________________ **Middle:**______________ **Last:**____________________
(Nombre) *(segundo nombre)* *(apellido)*

Sex: Male Female **Date of Birth:** ____________ **Age:** ________ **Marital Status:** D M S W
(sexo: masculino/femenino) (fecha de nacimiento) *(edad)* *(estado marital : D C S V)*

Race: _____________ **Ethnicity**: ______________________ **Preferred Launguage**: ____________
(Raza) *(Ethnicidad)* *(Idimoa Preferido)*

SS#:__________________**Address**____
(# de seguro social) *(direccion)*

City: ___________________________ **State:** ____________ **Zip Code:**_____________
(ciudad) *(estado)* *(area postal)*

Home Phone #: _______________ **Work #:** __________________**Cell #:** ___________________
(telefono de casa) *(telefono de trabajo)* *(celular)*

Email address:____
(correo electronico)

In case of Emergency Contact Person & Phone #:____
(en caso de emergencia contactar con y telefono)

Employer Name:_____________________________**Employer phone:**________________________
(nombre de empleador) *(telefono de empleador)*

Employer Address:____
(direccion de empleador)

Employed: Full Time___ **Part Time** ___ **Student**___ **Active Military**___ **Inactive Military**___
(empleo: tiempo completo medio tiempo estudiante militar activo militar inactivo)

Is this an accident related injury? ___**Yes** ___**No**
(el dolor es con relacion a un accidente? si no)

If Accident, where did it occur? ___**Home** ___**Work** ___**Auto** ___**School** ___**Other**: ____
(si es un accidente, adonde ocurrio? casa trabajo auto escuela otra)

Date of Accident? _____________ **Describe Accident:**_________________________________
(fecha de accidente) *(describir el accidente:)*

Have you seen another physician for this injury? ☐ **Yes** ☐ **No**
(A visto otro medico por esta lesion?) ☐ *Si* ☐ *No*
If yes, who?______________________
*Nombre del medico:*______________________________

Primary Care Physician & Phone#: ____
(Nombre y telefono de medico primario)

Referring Physician & Phone#: ____
(Nombre y telefono de medico que lo refirio)

How did you hear about us: ____

Cesar E. Ceballos, MD
7800 SW 87th Ave STE A-110
Miami, FL 33173
P 305-596-2828
F 305-596-6446

Insurance ***(Copy of Insurance Cards Required and Photo Identification)***
(Seguro) (Copia requerida de la tarjeta del seguro y foto de identificaction)

Insurance Company: ______________________ **Id#** ______________________ **Phone#**__________________
(Compania de seguro) (numero de indentificacion o miembro) (telefono)

Insured Party Name (Policyholder): ____________________________ **Relation:** Self Spouse Parent Other
(Nombre primario en la polica del seguro) (relacion: usted esposo padre otro)

Date of Birth: ______________________ **Sex: Male___ Female____ S.S.#**__________________________
(fecha de nacimiento) (sexo: masculino - femenino) (# de seguro social)

Please be advised there is a 24 hour cancellation policy- ALL "No Shows" will be charged a $50.00 fee

Insurance Authorization, Assignment and Financial Responsibility:

By signing below, you consent to the use and disclosure of your protected health information by Cesar E. Ceballos, M.D., P.A., its staff and business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for payment purposes including the disclosure of protected health information to insurance carriers concerning my illness and treatment. You may have the right to review our Notice prior to signing this consent.

I hereby assign to Cesar E. Ceballos, M.D., P.A. all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Signature: ____ **Date:** __________________
(Firma) (fecha)

.Cesar E Ceballos, MD
7800 SW 87th Ave STE A-110
Miami, FL 33173
P 305-596-2828
F 305-596-6446

____
Patient Name

____
SS#

____
DOB

Date: ______________

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

YOUR DOCTOR (Cesar E. Ceballos, MD) HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida Law subject to certain conditions. Florida law imposes penalties against uninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

I have read and understand the above statement.

____
Printed Name

____
Signature

Cesar E. Ceballos, MD
7800 SW 87th Ave STE A-110
Miami, FL 33173
P 305-596-2828
F 305-596-6446

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

____
Print Name of Patient:

______________________________ ________
Signature of Patient Date

Patient's Date of Birth: ___________

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative:

____

Describe Personal Representative Relationship
(parent, guardian, etc):

____

Signature of Personal Representative:

____

Date: ______________________________

For Practice Use Only:

____

____

____

____

____

____

Signature of Practice Employee **Date**

ORTHO MIAMI

Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos
- on-line videos

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Patient Signature____________________________ Date____________________________

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature____________________________ Date____________________________

Cesar E. Ceballos, MD, FAAOS

| T | F |