G&T SPORTS MEDICINE
ORTHOPAEDICS

IME REGISTRATION

Last Name_____ First Name_____ Middle_____

Date of Birth_____ Male_____ Female_____

Street Address_____

City_____ State_____ Zip Code_____

Phone_____ Social Security Number_____

If workers compensation injury, please complete this section

Employer at the Time of Injury_____

Employer's Address_____

Employer's Phone_____ Contact Person_____

Working Now?_____ With or Without Restrictions?_____

Current Work Restrictions_____

Current Job Title/Description_____

Is This Your Regular Job?_____ If Not, What is Your Regular Job?_____

Prior Job Title/Description_____

Did Symptoms Begin While Working at a Prior Job?_____

If Yes, List Job Title/Description and Company Name_____

If accident, please complete this section

Date of Accident_____ Place of Accident_____

Type of Accident_____

Release of Information Consent

I consent to this evaluation and physical examination. I authorize release and discussion of the information gathered to the requesting agent, insurance carrier, employer, or rehabilitation consultant and/or other medical professionals.

Signature of Examinee or Authorized Guarding_____

Date_____

PATIENT HEALTH HISTORY

G&T SPORTS MEDICINE ORTHOPAEDICS

Patient Name: _____ **Date of Birth:** ____/____/____

List medications you are currently taking: _____

_____

Allergies: None (circle if none)_____ **Previous Surgery**(ies)**:** Y N_____

FAMILY HISTORY:

Heart Disease____ Diabetes____ Hypertension____ Bleeding Problems____ Other_____

Do you smoke? Y N If you do, how much a day?_____How many years?_____

Do you drink alcohol? Y N If you do, how much a day?_____For how many years?_____

Do you/have you previously used drugs? Y N **Do you live alone?** Y N

Any information you provide will not be released and will only be used for the purpose of our office.

Please circle conditions you currently have or have had:

Anemia	Cancer	Gout	Migraine Headaches	Rheumatic
Anorexia	Cataracts	Heart disease	Mononucleosis	Scarlet Fever
Appendix	Chickenpox	Hepatitis	Multiple Sclerosis	Stroke
Arthritis	Diabetes	Hernia	Mumps	Thyroid Problem
Asthma	Emphysema	High Cholesterol	Pacemaker	Tuberculosis
Bleeding Disorders	Epilepsy	High Blood Pressure	Pneumonia	Typhoid Fever
Breast Lump	Glaucoma	Kidney Disease	Polio	Ulcers
Bronchitis		Liver Disease	Prostate Problem	Venereal Disease
Bulimia		Measles		

Please circle conditions you currently have or have had:

AIDS/HIV Positive Alcoholism Chemical Dependency Psychiatric Care

Please circle symptoms you currently have or have had <u>in the past 3 months:</u>

<u>GENERAL</u>
Chills
Depression
Dizziness
Fainting
Fever
Headache
Loss of sleep
Loss of weight
Gain of weight
Nervousness
Sweats

<u>MUSCLE/JOINT/ BONE</u> (Pain, Weakness, Numbness in)
Arms – Hips
Back – Legs
Feet – Neck
Hands – Shoulders

<u>GASTROINTESTINAL</u>
Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Nausea
Rectal bleeding
Stomach Pain
Vomiting
Vomiting Blood

<u>SKIN</u>
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal

<u>EYE,EAR,NOSE,THROAT</u>
Bleeding gums
Hoarseness
Nosebleeds
Persistent cough
Ringing in ears

<u>CARDIOVASCULAR</u>
High Blood Pressure
Irregular Heartbeat
Low Blood Pressure
Poor Circulation
Rapid Heartbeat
Swelling of Ankles
Varicose Veins
Chest Pain

<u>WOMEN ONLY</u>
Abnormal pap spear
Bleeding between periods
Breast Lump
Hot Flashes
Are you pregnant?__
No. of children___

<u>GENITO-URINARY</u>
Blood in urine
Frequent Urination
Lack of Bladder control
Painful Urination

G&T ORTHOPAEDICS
AND SPORTS MEDICINE

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Suite 301
Chicago, IL 60659
773.463.2377

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Suite 2011
Elk Grove Village, IL 60007
847.439.2314

1200 South York Road
Suite 4190
Elmhurst, IL 60126
630.782.1174

Notice of Privacy Practices Acknowledgement

This notice advises you about the ways in which we may use and disclose your protected health information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that relates to your past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to your PHI. The law requires us to provide a copy of this notice to you, which explains our legal duties and privacy practices.

My signature acknowledges that I have been offered a copy of G&T Orthopaedics and Sports Medicine, S.C. Notice of Privacy Practices at the time of registration, or previously viewed online.

Signature_____Date_____

Notification del Reconocimiento de la Politica de Privacidad

Esta nota es para informarle a usted acerca de las formas en que nosotros podemos revelar su informacion protegida medica (PHI). Informacion protegida medica significa cualquier informacion medica que se pueda utilizar para identicarlo a usted y es posible que este relacionada con su salud o condicion fisica o mental pasada, actual, o futura y relacionados con servicios medicos. Tambien describe sus derechos y nuestras obligaciones con respecto a su informacion protegida medica. La ley requiere que nosotros le proveamos a usted esta nota de aviso en la cual se explican nuestras obligaciones legales y politicas de privacidad.

Con mi firma reconzco que me han ofrecido una copia del G&T Orthopaedic and Sports Medicine, S.C. Notice of Privacy al momento de registracion. Lo mismo pero en español.

Firma_____Fecha_____