PATIENT INFORMATION

Date _____

Last Name_____First_____Middle_____

Preferred Name _____

Age _____ Date of birth _____ Sex ☐ M ☐ F SS#_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other _____

Address _____

City _____ State _____ Zip_____

Home phone (____) _____ Work phone (____) _____

Cell Phone (____) _____ Email _____

Spouse Name _____ Phone Number _____

Who is your Primary Care Physician? _____

How did you hear about our practice? _____

Reason for today's visit: _____

Place of Employment: _____

If injury, give date _____ or date of first symptoms _____

Please circle where the Injury occurred:

JOB AUTO HOME OTHER

Have X-rays been taken? ☐ Yes ☐ No When?_____ Where?_____

PAYMENT INFORMATION

Name of person responsible for payment _____

Do you have insurance coverage? ☐ Yes ☐ No

PRIMARY INSURANCE _____

Policy holder _____

Policy holder's ID# _____

Policy holder's Group # _____

Policy holder's date of birth _____

Policy holder's Social Security Number _____

SECONDARY INSURANCE _____

Policy holder _____

Policy holder's ID# _____

Policy holder's Group # _____

Policy holder's date of birth _____

Policy holder's Social Security Number _____

Welcome to our practice. Please fill out the information below to the best of your ability.

Today's Date: _____

Patient's Name _____ Age _____ Date of Birth _____ M / F

Chief Complaint _____

PAST MEDICAL HISTORY

Have you ever had any of the following? Please check all pertinent boxes.

- ☐ Aids or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Trouble
- ☐ Bladder Infections
- ☐ Bleeding Tendency
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer

PAST SURGICAL HISTORY

Please list previous Hospitalizations / Surgeries / Serious Illnesses When? Hospital, City, State

_____

_____

_____

_____

MEDICATIONS

Please include non-prescription and Herbal Supplements

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

ALLERGIES

Medication	Reaction	Medication	Reaction

Tape Allergy ☐ Yes ☐ No **Latex Allergy** ☐ Yes ☐ No

FAMILY HISTORY

Things that members of your family have

- ☐ Back Pain
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug/Alcohol Dependence
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Sudden Death
- ☐ Tuberculosis

PATIENT SOCIAL HISTORY

Marital Status
- ☐ Divorced
- ☐ Married
- ☐ Separate
- ☐ Single
- ☐ Widowed

Use of Alcohol
- ☐ Daily
- ☐ Moderate
- ☐ Never
- ☐ Rarely

Use of Tobacco
- ☐ Currently
- ☐ Never
- ☐ Previously, but quit

_____
Packs per day

Living Situation
- ☐ Alone
- ☐ Other

_____
- ☐ With Family
- ☐ With Friends

Dominant Hand
- ☐ Right
- ☐ Left

Date	Date	Date	Date	Date	Date
Patient	Patient	Patient	Patient	Patient	Patient
Doctor	Doctor	Doctor	Doctor	Doctor	Doctor

PATIENT HISTORY

The following questions pertain to symptoms the patient is experiencing or experiences on a regular basis. These questions pertain to the patient only:

CONSTITUTIONAL

Weight Loss	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Night Sweats	☐ YES	☐ NO
Problems with Anesthesia	☐ YES	☐ NO

EYES:

Metal in Eye	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO

ENT:

Nose Bleeds	☐ YES	☐ NO
Ear Ringing	☐ YES	☐ NO
Sore Throat	☐ YES	☐ NO
Hearing Loss	☐ YES	☐ NO

CARDIOVASCULAR:

Chest Pain	☐ YES	☐ NO
Leg Swell	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO
Irregular Beat	☐ YES	☐ NO
Heart Attacks	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Blood Clot Lung/Legs	☐ YES	☐ NO

RESPIRATORY:

Irregular	☐ YES	☐ NO
Shallow	☐ YES	☐ NO
Cough	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO

GASTROINTESTINAL:

Nausea/Vomiting	☐ YES	☐ NO
Change in Bowel Habits	☐ YES	☐ NO
Distension	☐ YES	☐ NO
Tarry Stools	☐ YES	☐ NO
Bloody Stools	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO

GENITOURINARY:

(Reproductive & Urinary Systems)

Frequency in Urination	☐ YES	☐ NO
Burning	☐ YES	☐ NO
Frequent Urination at Night	☐ YES	☐ NO
Frequent Infections	☐ YES	☐ NO
Bloody Urine	☐ YES	☐ NO
Inability to Control Bladder	☐ YES	☐ NO
Inability to Urinate	☐ YES	☐ NO
Prostate Problems	☐ YES	☐ NO

NEUROLOGICAL:

Fainting Spells	☐ YES	☐ NO
Seizures	☐ YES	☐ NO
Amnesia	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Headache	☐ YES	☐ NO
Paralysis	☐ YES	☐ NO
Stimulator Implant	☐ YES	☐ NO

MUSCULOSKELETAL:

Back Pain	☐ YES	☐ NO
Neck Pain	☐ YES	☐ NO
Leg Pain	☐ YES	☐ NO
Joint Swelling	☐ YES	☐ NO
Fractures	☐ YES	☐ NO
Arm Pain	☐ YES	☐ NO

ENDOCRINE

Do you have diabetes?	☐ YES	☐ NO
Do you take insulin?	☐ YES	☐ NO
Hair Gain?	☐ YES	☐ NO
Hypoglycemia	☐ YES	☐ NO
Hyperglycemia	☐ YES	☐ NO

PSYCHIATRIC

Anxiety	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Hallucinations	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO
Compulsive Behaviors	☐ YES	☐ NO
Impulsive Behaviors	☐ YES	☐ NO
Suicidal Ideation	☐ YES	☐ NO

HEME-LYMPH

Lightheadedness	☐ YES	☐ NO
Easy Bleeding	☐ YES	☐ NO
Easy Bruising	☐ YES	☐ NO
Petechiae	☐ YES	☐ NO
Purpura	☐ YES	☐ NO
Lymph Node Enlargement	☐ YES	☐ NO
Pica	☐ YES	☐ NO

ALLERGIC-IMMUNOLOGICAL

Sinus Allergy Symptoms	☐ YES	☐ NO
Allergic Dermatitis	☐ YES	☐ NO
Frequent Illness	☐ YES	☐ NO

PLEASE USE THIS SPACE TO LIST ANY INFORMATION THAT HAS NOT BEEN MENTIONED ABOVE THAT YOU FEEL WOULD BENEFIT THE DOCTOR IN HIS TREATMENT OF YOUR CASE.

DATE REVIEWED BY:					
DATE REVIEWED BY:					
DATE REVIEWED BY:					
DATE REVIEWED BY:					

Southern Orthopaedics & Sports Medicine, P.A.

Please list the family member or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care):

_____

Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name:_____ Phone#_____

Name:_____ Phone#_____

Print the address of where you would like your billing statement and/or correspondence from our office to be sent **IF** other than your home:

_____

Please print the telephone number where you want to receive calls about your appointments, or other health care information **IF** other than your home phone#

_____

Do you have voicemail or an answering machine? YES:_____ NO:_____

Can confidential messages (such as appointment reminders) be left on your voicemail or answering machine? YES:_____NO:_____

PATIENT NAME:_____(guardian if patient is under 18 years old)

PATIENT/GUARDIAN SIGNATURE:_____

DATE:_____