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.

_____

_____

_____

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 _____

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:_____

Southern Orthopaedics & Sports Medicine, P.A.

NARCOTIC AGREEMENT

The purpose for this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- I understand this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement.
- I understand that if I break this agreement, my doctor may stop prescribing these pain-control medications and/or release me from the practice. If this occurs, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.
- I understand that if I am being prescribed pain medication by another physician that I must notify that physician regarding medication prescribed to me by the physician listed below.
- I will not use any illegal controlled substances, such as marijuana and cocaine. I will not share, sell or trade my medication with anyone.
- I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.
- I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written, or filled, **will not be replaced**.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or weekends**.
- I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State of Florida's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine.
- I authorize my doctor to provide a copy of this agreement to my pharmacy.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time.
- If requested by my doctor, I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given upon request.

I agree to use _____(pharmacy), located at_____(address)
_____(telephone number), for filing prescriptions for all of my pain medications.

Patient Name: _____ DOB: _____ Date: _____
Patient Signature:_____ Witness: _____
Physician Name: William E. Smith Jr. M.D.
Physician Signature: _____