

Patient # _____

PATIENT INFORMATION SHEET FOR SARASOTA ORTHOPEDIC ASSOCIATES

Date _____

PATIENT NAME _____

EMAIL _____

BIRTHDATE _____ AGE _____ SS# _____

MARITAL STATUS _____ SEX _____ HT: _____ WT: _____

REFERRED BY _____

FAMILY PHYSICIAN _____

PATIENT ADDRESS _____ APT # _____

OUT OF TOWN ADDRESS _____ APT # _____

CITY, STATE, ZIP _____

CITY, STATE, ZIP _____

HOME PHONE _____ CELL _____

OUT OF STATE PHONE _____

IS LITIGATION INVOLVED (Y/N) IF SO,

ATTORNEY'S NAME & ADDRESS _____

PROBLEM FOR WHICH YOUR ARE SEEKING TREATMENT: RIGHT/LEFT _____

DATE PROBLEM BEGAN _____

CAUSE (FELL, ETC.) _____

PAST TREATMENTS (BY WHOM, HOSPITAL. ETC.) _____

WERE YOU INJURED ON THE JOB? Y N

WAS AN AUTOMOBILE INVOLVED? Y N

WERE X-RAYS TAKEN OF THE PROBLEM? Y N IF YES, WHERE WERE THEY TAKEN & DATE _____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE Y N

NAME AND ADDRESS OF FAMILY MEMBER NOT LIVING IN THE HOME _____

PAST MEDICAL HISTORY

ALLERGIES YES OR NO

ASPIRIN _____

PENICILLIN _____

NOVACAINE _____

SULFA _____

OTHERS _____

RIGHT HANDED

LEFT HANDED

AMBIDEXTROUS

*** LIST ALL PAST SURGERIES**

Not just Orthopedic

1. _____ Year _____ SURGEON _____

2. _____ Year _____ SURGEON _____

3. _____ Year _____ SURGEON _____

4. _____ Year _____ SURGEON _____

PRESENT MEDICATIONS

DRUG STRENGTH FREQUENCY

1. _____

2. _____

3. _____

4. _____

TOBACCO

SMOKE? _____

AMOUNT _____ / Years? _____

ALCOHOL

NONE _____

SOCIAL _____

HEAVY _____

MEDICAL PROBLEMS

YES OR NO

HEART _____

ULCERS _____

LUNGS _____

HEPATITIS _____

DIABETES _____

LIVER _____

OTHER _____

BLEEDING PROBLEMS _____

WEAK STOMACH _____

BLOOD PRESSURE _____

BLOOD TRANSFUSIONS _____

IF FEMALE, ARE YOU

PREGNANT? _____

CANCER _____

SOCIAL HISTORY

RECREATIONAL SPORTS (HOW OFTEN, HOW SERIOUS) _____

JOB DESCRIPTION _____

LEVEL OF ACTIVITY ASSOCIATED WITH JOB (HEAVY LIFTING, SQUATTING, ETC.) _____

GUARANTOR AND ADDRESS IF DIFFERENT THAN PATIENT _____

INSURED'S: DATE OF BIRTH _____ SS# _____ EMAIL _____

EMPLOYER _____ WORK PHONE _____

EMPLOYER'S ADDRESS _____ OCCUPATION _____

_____ HOW LONG EMPLOYED? _____

1st INS COMP _____ 2nd INS COMP _____

ADDRESS _____ ADDRESS _____

POLICY HOLDER _____ POLICY HOLDER _____

POLICY NUMBER _____ POLICY NUMBER _____

THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE

PATIENT'S OR PARENT'S SIGNATURE _____ **DATE** _____