Southern Orthopaedic Specialists, P.C.

(Patient Information and Profile)

Name: _____DOB: _____ Age: ___ Race: ___ Preferred Language: _____

Marital Status: Single: __ Married: __ Widowed: __ Divorced: __ Ethnicity: __Hispanic: __Not Hispanic

Females Only: Are you pregnant? Yes: __ No: __ If "No", Date of last menstrual period: ___/___/___

Do you have a Primary Physician? Yes: __ No: __ If "Yes", what is his/her name? _____

Who referred you to our office? (Doctor, Patient, or a Friend) _____

Reason for today's visit: _____

Is your problem due to an accident? Yes: ___ No: ___ If "Yes", what is the date of injury? ___/___/___

Where did your injury occur? _____ How did your injury occur? _____

_____

Do you have drug allergies? Yes: __ No: __ If "Yes", please list drug and reaction: _____

_____

Are you allergic to Betadine, Adhesive Tape, Xylocaine, or Latex? (If yes, please circle those that apply)

Have you ever experienced any complications with anesthesia? Yes: ____ No: ____

If "Yes", please explain: _____

Are you currently taking blood thinners (Coumadin, Plavix, Aspirin, etc.)?_____

List **all** medications that you are currently taking. Please also include **all** over the counter medications:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Please list pharmacy name and phone number: _____

Please list previous surgeries and approximate dates of these procedures:

1. _____ Date: ___/___/___

2. _____ Date: ___/___/___

3. _____ Date: ___/___/___

4. _____ Date: ___/___/___

PLEASE CONTINUE ON NEXT PAGE

List any medical conditions affecting your immediate family:

1. _____ Relation: _____

2. _____ Relation: _____

3. _____ Relation: _____

4. _____ Relation: _____

Do you currently smoke tobacco? ____; Use smokeless tobacco? ____ How long? ___Years,____Months

Date of last colonoscopy?_____ Date of last pneumonia vaccination?_____
Do you have an advanced directive?_____
Do you consume alcoholic beverages?_____ If yes, how many per week?_____

GENERAL MEDICAL HISTORY

GENERAL
___Weight Change
___Cancer
___Diabetes
___Fever or Chills
___Fibromyalgia
___Frequent Dizziness
___Glasses or Contacts
___Itching or Rash
___Lumps or Masses
___Night Sweats
___Severe Childhood Illness
___Sleep Disorder
___Thyroid Problems
___Urinary Frequency

GASTROINTESTINAL
___Acid Reflux
___GI Ulcers or Bleeding
___Jaundice/Hepatitis
___Nausea or Vomiting

CARDIOVASCULAR
___Heart Attack
___Heart or Chest Pain
___Heart Disease
___High Blood Pressure
___Mitral Valve Prolapse
___Atrial Fibrillation
___Heart Bypass

RESPIRATORY
___Asthma
___Chronic Bronchitis
___Cough/Sputum
___Emphysema/COPD
___Pleurisy/Pneumonia
___Rheumatic Fever
___Shortness of Breath
___Tuberculosis
___Sleep Apnea

NEUROLOGIC
___Numbness
___Paralysis
___Seizures
___Stroke
___Weakness
___Headaches

EYE-EAR-NOSE-THROAT
___Bleeding Gums
___Glaucoma
___Ringing in Ears
___Visual Change

MUSCULOSKELETAL
___Backache
___Gout
___Joint Pain
___Joint Swelling
___Lupus
___Sciatica

GENITOURINARY
___Incontinence
___Kidney Failure
___Urinary Tract Infection
___Venereal Disease

**Do you currently have a pacemaker? ___Yes ___No

EMAIL address_____

Signature of Patient or Guardian: _____ **Date:** ___/___/___