SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C.

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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: ___ "No", Date of last menstrual period: __/__/__

Do you have a Primary Physician? Yes: ___ No: ____If 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 <u>all</u> medications that you are currently taking. Please also include **<u>all</u>** over the counter medications: (If you have a separate list of medications, attach it to this form and write "see list" below)

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

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

Please list pharmacy name, phone number, and zip code: _____

Please list previous surgeries and approximate dates of these procedures:

1._____ Date:__/__/__

2. _____ Date:__/__/__

3. _____ Date:__/__/__

4. _____ Date:__/__/__

5. _____ Date:__/__/__

List any medical conditions affecting your immediate family:

1. _____ Relation: _____
2. _____ Relation: _____
3. _____ Relation: _____
4. _____ Relation: _____

Do you currently smoke tobacco?_____; Use smokeless tobacco?___ Packs per day?___ # of years?_____

Date of your last colonoscopy? _____Date of your last pneumonia vaccine? _____

Do you have an advanced directive? _____

Do you consume alcoholic beverages? _____ On average, how many drinks do you consume per day? ____

GENERAL MEDICAL HISTORY

CARDIOVASCULAR
__ Heart Attack
__ Heart or Chest Pain
__ Heart Disease
__ High Blood Pressure
__ Mitral Valve Prolapse
__ Atrial Fibrillation
__ Heart Bypass
__ Bleeding Disorder
__ Blood Clots
__ Hypercholesterolemia

ENDOCRINE
__ Diabetes (Type I/ Type 11)
__ Thyroid Disorders

EYE-EAR-NOSE-THROAT
__ Bleeding
__ Glaucoma
__ Ringing in ears
__Visual Change

GASTROINTESTINAL
__Acid Reflux
__GI Ulcers or Bleeding
__Jaundice/Hepatitis
__Liver Disease
__Nausea or Vomiting

GENERAL
__Cancer
__Fever or Chills
__Glasses or Contacts
__Lumps or Masses
__Night Sweats
__Sleep Disorder
__Vertigo
__Weight Change
__HIV
__AIDS

GENITOURINARY
__Incontinence
__Kidney Failure
__Urinary Tract Infection
__Venereal Disease
__Urinary Frequency

MUSCULOSKELETAL
__Backache
__Gout
__Joint Pain
__Joint Swelling
__Lupus
__Sciatica
__Neuropathy
__Osteoarthritis
__Osteoporosis
__Fibromyalgia
__Rheumatoid Arthritis

NEUROLOGIC
__Numbness
__Paralysis
__Seizures
__Stroke
__Weakness
__Headaches
__Cerebral Palsy

PSYCHOLOGICAL
__Anxiety
__Bipolar Depression
__Depression

RESPIRATORY
__Asthma
__Chronic Bronchitis
__Emphysema/COPD
__Pleurisy/Pneumonia
__Shortness of Breath
__Tuberculosis
__Sleep Apnea

****Do you currently have a pacemaker?** _Yes _No

EMAIL address:_____

Signature of Patient or Guardian:_____ **DATE:__/__/__**