Patient # _____

Date _____

PATIENT INFORMATION SHEET FOR SARASOTA ORTHOPEDIC ASSOCIATES

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 _____

PRESENT MEDICATIONS

	DRUG	**STRENGTH**	**FREQUENCY**
1.			
2.			
3.			
4.			

RIGHT HANDED ❑ LEFT HANDED ❑ AMBIDEXTROUS ❑

TOBACCO

SMOKE? _____

AMOUNT _____ / Years? _____

ALCOHOL

NONE _____

SOCIAL _____

HEAVY _____

*** LIST ALL PAST SURGERIES**

Not just Orthopedic	**Year**	**SURGEON**
1.		
2.		
3.		
4.		

MEDICAL PROBLEMS

YES OR NO

HEART _____ BLEEDING PROBLEMS _____

ULCERS _____ WEAK STOMACH _____

LUNGS _____ BLOOD PRESSURE _____

HEPATITIS _____ BLOOD TRANSFUSIONS _____

DIABETES _____ IF FEMALE, ARE YOU

LIVER _____ PREGNANT? _____

OTHER _____ 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** _____