

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

Year

SURGEON

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**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** \_\_\_\_\_