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 *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 <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. _____

Your pharmacy's 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 (blood relatives only):

1. _____ Relation: _____

2. _____ Relation: _____

3. _____ Relation: _____

4. _____ Relation: _____

Do you currently smoke tobacco? ___Yes ___No **Do you use smokeless tobacco?** ___Yes ___No

How long? ____ Years, ____ Months *How many packs do you/did you smoke per day?* _____ Packs/day

Do you currently consume alcoholic products? Yes: ____ No: ____

If "Yes", how many drinks per day? I consume about _____ Drinks/day on average

GENERAL MEDICAL HISTORY

GENERAL

___Bleeding
___Blood Clots
___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
___Weight Change

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: _____ **Today's Date:** _____/_____/_____