

**FLORIDA SPORTSMEDICINE AND ORTHOPAEDICS, P.A.
NEW PATIENT MEDICAL HISTORY**

This form must be filled out before you see the physician. The information on the form provides basic information about your orthopedic problem and general health condition.

Today's Date _____ Referred by _____

Name _____ Sex ____ Date of Birth _____ Age _____

Height _____ Weight _____ Are you right handed / left handed ambidextrous

Were you hurt at work? (on the job?) Yes No

Present Illness	Print your answer	Office Use (do not write)
What orthopedic problem are you being seen for?		
When did it first occur?		
Where is the problem located? Right or Left		
If you have pain: (1) Describe it (constant, intermittent, dull, sharp, aching, burning, shooting). Rate it (0 is no pain, 10 worst pain ever)		
What relieves the symptom?		
What makes the symptom worse?		
Have you ever had a similar problem before?		
What medical tests or treatment have you received for this problem?		

Other orthopedic problems: Circle any of the following that you have had. Indicate right or left and joint location if applicable under the condition. Example: Dislocated Joint - Right Shoulder

- | | | |
|--------------------------|----------------------|------------------|
| Recurrent joint swelling | Recurrent joint pain | Dislocated joint |
| Joint/bone infection | Bone Spurs | Gout |
| Arthritis | Decreased movement | Torn cartilage |
| Bursitis/Tendonitis | Torn Ligament/tendon | Joint looseness |

Allergies (list all medications, tapes, iodine's and food: _____)

Current Medications (list all medication you are taking, including aspirin and herbal medications: _____)

Past Surgical History (include all surgeries since childhood):

Year	Surgery	Year	Surgery

Do you have a family physician? Yes No Name of Physician _____

Other Surgery Questions

Have you received any blood transfusions? (list year received) _____

Have you ever had an infection after surgery? _____

Have you ever had problems with anesthesia? _____

Have you or a family member ever had bleeding problem after surgery? _____

Family Medical History

(Do any of your blood relatives have or have they ever had the following conditions?)

***Blood Relatives ONLY - If yes, please circle**

Arthritis	Seizures	Kidney Disease	Diabetes
Cancer	Epilepsy	Lung Disease	Strokes
Heart Problems	Hypertension	Thyroid Disease	High BP

Personal/Social History

Do you smoke cigarettes? Yes No ____ Packs per day. For how many years _____

Did you smoke in the past and quit? Yes No How long ago did you quit? _____

Do you drink alcohol? Never Occasionally Socially Regularly Excessively

Are you employed? Full Time Part Time Retired Housewife Student

What type of work do you do? _____

Marital Status – (are you) Single Married Divorced Separated Widowed

Religious Beliefs - Christian Catholic Baptist Jehovah's Witness Jewish
Other: _____

Do you have any children? Yes No How many? _____

Review of Systems

Please circle any of the following conditions that you have had or are presently being treated for

Eyes: Cataracts, Glaucoma, Eye Pain, Sudden loss of vision, double vision

ENT: Sudden loss of hearing, Ringing in ears, Vertigo, Ear infections, Drainage from ear, Sinus infections, Sleep Apnea

Skin: Herpes Simplex, Sores, Rashes, Change in color or size of moles, Lumps

Breast: Cancer, Benign Growth

Cardiovascular: High blood pressure, Low blood pressure, Rheumatic fever, Heart attack, Chest pain, Irregular heart beat, Swelling in both legs or ankles, High cholesterol

Respiratory: Asthma, Bronchitis, Recurrent cough, Wheezing, Coughing up blood, Shortness of breath, Positive skin test for TB, Tuberculosis, Pneumonia

GI: Problems taking NSAID, Recurrent nausea or vomiting, Loss of bowel control, Rectal bleeding, Blood in stool, Recurrent constipation or diarrhea, Liver or gallbladder problems, Hepatitis A – B – C (circle one)

GU: Acute renal failure, Chronic renal failure, Dialysis, Loss of kidney, Kidney stones, Burning on urination, Recurrent bladder or kidney infections

OB-GYN: (women only) Are you currently pregnant? Yes No Not Sure

Musculoskeletal: Bone cancer, Cold extremities, Degenerative Joint Disease, Rheumatoid arthritis, Weakness in muscle joint, Gout, Osteoporosis

Neurological: Blackouts, Frequent numbness or tingling in a body part, Neuromuscular, Paralysis, Seizures or convulsions, Migraines, Epilepsy, Parkinson's, Dizziness

Hematologic/Lymphatic: Anemia, Bleeding disorder, Easy bruising, Low platelets, Enlarged Lymph Nodes, Swollen Glands

Vascular: Anemia, Bleed Clot Problem, Varicose Veins, DVT, Hemophilia, Phlebitis

Endocrine: Diabetes Type _____, Hyperthyroid, Hypothyroid, Excessive urination, Excessive sweating

Immune System: AIDS, Blood Transfusion, Immuno Suppression, IV Drug Abuse

Additional Conditions that you have had or being treated for that you would like us to be aware of:

