Nature Coast Orthopaedics Patient Information

Name:_____ DOB:_____ Age:_____
Email Address:_____
Most Recent Occupation:_____ Retired?: No Yes
Allergies:_____ Reaction:_____
Family Doctor:_____
Reason for today's visit:_____
Where is the pain?_____ When did it start?_____
What makes it feel better?_____ Worse?_____
Have you seen any other MD for it? No Yes Who? _____
Is this injury a result of a motor vehicle accident? No Yes When? _____
Is this injury as a result of a work-related accident? No Yes When? _____
Is this injury as a result of a slip/fall liability accident? No Yes Where? _____
Please list all past **operations** with dates/year performed.

1._____ 4._____ 7._____
2._____ 5._____ 8._____
3._____ 6._____ 9._____

Please list all current **medical problems**. Please list all past medical problems indicating dates/year.

1._____ 4._____ 7._____
2._____ 5._____ 8._____
3._____ 6._____ 9._____

Please list all current **medications** and their doses/mg.

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

Have you had any of the below symptoms in the last year? If yes to any please explain.
Do you have a family history of the below symptoms? Please indicate which family member.

	Patient:	**Family History**:
Chest pain?	No Yes _____	No Yes _____
Shortness of breath?	No Yes _____	No Yes _____
Unexplained weight loss?	No Yes _____	No Yes _____
Cancer?	No Yes _____	No Yes _____
Kidney problems?	No Yes _____	No Yes _____
Liver problems?	No Yes _____	No Yes _____
Heart problems?	No Yes _____	No Yes _____
Bleeding Disorders?	No Yes _____	No Yes _____
Anesthesia problems?	No Yes _____	No Yes _____

Do you smoke? No Yes How much?_____ Former Smoker? No Yes
Do you drink alcohol? No Yes How much?_____ Year Stopped Smoking:_____
Preferred language: _____ Ethnicity: Hispanic/Latino: No Yes
Race (s): African or African American, Asian or Asian American, Caucasian or European American, Native American or Alaska Native, Native Hawaiian or Other Pacific Islander, Other Race

_____ _____
Date Signature (Patient, Parent or Responsible Party)