Nature Coast Orthopaedics Patient Information

Name:_____ **Date:**_____ **Age:**_____
Last Name First Name

Email Address:_____

Most Recent Occupation:_____ **Retired?: Yes No**

Allergies:_____ **Reaction:**_____

Family Doctor:_____

History: 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?_____ Yes_____ No_____

Is this injury a result of a motor vehicle accident?_____ Yes_____ No_____

Is this injury as a result of a work-related accident?_____ Yes_____ No_____

Is this injury as a result of a slip/fall liability accident?___ Yes_____ No_____

Past operations and dates/year performed (Please list):

1._____ 4._____

2._____ 5._____

3._____ 6._____

All current and past medical problems (Please list):

1._____ 4._____

2._____ 5._____

3._____ 6._____

All current medicines and their doses/mg (Please list):

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Have you had any of these symptoms in the last year? If yes to any please explain.
Is there a family history of any of these symptoms? If yes write mother/father/brother/sister.

Chest pain?	Yes	No	_____
Shortness of breath?	Yes	No	_____
Unexplained weight loss?	Yes	No	_____
Cancer?	Yes	No	_____
Kidney problems?	Yes	No	_____
Liver problems?	Yes	No	_____
Heart problems?	Yes	No	_____
Bleeding disorders?	Yes	No	_____
Anesthesia problems?	Yes	No	_____

Do you smoke? Yes No **How much?**_____ **Former Smoker?** Yes No

Do you drink alcohol? Yes No **How much?**_____

Preferred language: _____

Ethnicity: Hispanic/Latino: Yes No

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)