

# HEALTH HISTORY

Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## HISTORY OF PRESENT ILLNESS

Chief Complaint (Why are you here?) \_\_\_\_\_

How were you hurt? \_\_\_\_\_

How long ago? \_\_\_\_\_ Have you stopped working due to this injury/illness? \_\_\_\_\_ If so, when? \_\_\_\_\_

Referring Doctor \_\_\_\_\_

### ALLERGIES: ARE you allergic to (check):

- None     Penicillin     Sulfa     Demerol     Aspirin     Codeine     Morphine  
 Other Drugs \_\_\_\_\_

### PAST MEDICAL HISTORY:

- High Blood Pressure     Heart Attack     Diabetes     Kidney Failure     Hepatitis     Cancer (Type)  
 High Cholesterol     Stroke     Thyroid     Other: \_\_\_\_\_

### PAST SURGICAL HISTORY:

- Heart Bypass     Appendix     Gallbladder     Hysterectomy     Neck/Back Surgery (type)  
 Joint Replacement (type)     Other \_\_\_\_\_

Are you or might you be pregnant?     Yes     No

### SOCIAL HISTORY:

Marital Status:     Married     Single     Widowed

Work: Occupation \_\_\_\_\_ Where \_\_\_\_\_

Habits: Do you smoke cigarettes?     Yes     No    Pack per day \_\_\_\_\_

Alcoholic beverages?     Never     Daily     Social

### REVIEW OF SYMPTOMS (Last six months) Please read carefully and check where appropriate.

- |  |   |   |
|--|---|---|
| <p>1. General</p> <p>Recent weight change (up or down) ..... <input type="checkbox"/></p> <p>Chills ..... <input type="checkbox"/></p> <p>Fever ..... <input type="checkbox"/></p> <p>2. HEENT</p> <p>Headache ..... <input type="checkbox"/></p> <p>Change in vision ..... <input type="checkbox"/></p> <p>Ear pain ..... <input type="checkbox"/></p> <p>Nose bleed ..... <input type="checkbox"/></p> <p>Hoarseness ..... <input type="checkbox"/></p> <p>3. Respiratory</p> <p>Shortness of breath ..... <input type="checkbox"/></p> <p>Wheezing ..... <input type="checkbox"/></p> <p>Asthma ..... <input type="checkbox"/></p> <p>Pneumonia ..... <input type="checkbox"/></p> <p>4. Cardiovascular</p> <p>Shortness of breath with exercise ..... <input type="checkbox"/></p> <p>Shortness of breath on lying down ..... <input type="checkbox"/></p> <p>Chest pain ..... <input type="checkbox"/></p> <p>Heart palpitations ..... <input type="checkbox"/></p> | <p>5. Gastro Intestinal</p> <p>Vomiting blood ..... <input type="checkbox"/></p> <p>Heartburn ..... <input type="checkbox"/></p> <p>Blood in stool ..... <input type="checkbox"/></p> <p>Ulcer ..... <input type="checkbox"/></p> <p>6. Urinary</p> <p>Kidney infection ..... <input type="checkbox"/></p> <p>Kidney stones ..... <input type="checkbox"/></p> <p>7. Skin</p> <p>Rash ..... <input type="checkbox"/></p> <p>Skin cancer ..... <input type="checkbox"/></p> <p>Hives ..... <input type="checkbox"/></p> <p>Psoriasis ..... <input type="checkbox"/></p> <p>8. Neurological</p> <p>Headaches ..... <input type="checkbox"/></p> <p>Seizures ..... <input type="checkbox"/></p> <p>Stroke ..... <input type="checkbox"/></p> <p>Head trauma ..... <input type="checkbox"/></p> <p>9. Psychiatric</p> | <p>Depression ..... <input type="checkbox"/></p> <p>Anxiety ..... <input type="checkbox"/></p> <p>Psychiatric problem or hospitalization ..... <input type="checkbox"/></p> <p>10. Musculoskeletal</p> <p>Arthritis ..... <input type="checkbox"/></p> <p>Joint pain ..... <input type="checkbox"/></p> <p>Joint stiffness ..... <input type="checkbox"/></p> <p>Joint swelling ..... <input type="checkbox"/></p> <p>Rheumatism ..... <input type="checkbox"/></p> <p>Broken bone ..... <input type="checkbox"/></p> <p>11. Hematology</p> <p>Anemia ..... <input type="checkbox"/></p> <p>Bleeding problems ..... <input type="checkbox"/></p> <p>Blood clots ..... <input type="checkbox"/></p> <p>Transfusions ..... <input type="checkbox"/></p> |
|--|---|---|

### FAMILY HISTORY

	Living	Deceased	Age	Arthritis	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Cancer - Type?	Other
Father										
Mother										
Brother										
Sister										
Brother										
Sister										
Brother										
Sister										

HT \_\_\_\_\_ WT \_\_\_\_\_ RES \_\_\_\_\_

**FLORIDA ORTHOPAEDIC ASSOCIATES, P.A.**  
**Financial Policy**

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. Your signature below indicates you have read this form and you understand and accept this policy.

**INSURANCE**

As a courtesy to our patients, we do participate in many managed care plans. Please check with your insurance company to determine if Florida Orthopaedic Associates, P.A. participates in your plan.

**RESPONSIBILITY FOR ACCOUNT**

I understand that it is my responsibility to pay any deductible amount, co-insurance and any balance not covered by my insurance company. I am also responsible for providing complete and accurate insurance information to Florida Orthopaedic Associates, P.A. In the event I am unable to provide such information, I am responsible for payment at the time of service.

**PAYMENT/COLLECTION INFORMATION**

For the convenience of our patients, Florida Orthopaedic Associates, P.A. accepts checks, cash, Visa, MasterCard and American Express. There will be a \$30 charge for any returned checks.

I understand that my portion of all fees is due at the time of service. If I am unable to pay for today's charge in full, I will make payment arrangements prior to my appointment

If my account balance becomes delinquent, Florida Orthopaedic Associates, P.A. may place my account with an outside collection service. All delinquent accounts are subject to agency fees, attorney fees and court costs.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guarantor (if patient is a minor)

\_\_\_\_\_  
Date