

FIRST COAST ORTHOPEDICS

1679 Eagle Harbor Parkway, Suite B
 Fleming Island, FL 32003-4816
 TEL: (904)278-4447 FAX:(904)278-4425

PATIENT PROFILE – Please complete all sections

NAME: _____ **DOB:** ____/____/____
DATE: ____/____/____ **PRIMARY DR:** _____
INSURANCE CO: _____
OCCUPATION: _____ **EMPLOYER:** _____
How did you hear about us? _____
Email address _____

MEDICATIONS: None

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

ALLERGIES: DRUGS: _____
OTHER: _____
REACTION: _____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: *Check all that apply to YOU*

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> TB or (+) Test	<input type="checkbox"/> Neurologic Dz.	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Psychological Dz.	<input type="checkbox"/> Gout
<input type="checkbox"/> GI Disease	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Depression
<input type="checkbox"/> Urinary Disease	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Seizures	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Autoimmune Dz.	<input type="checkbox"/> Steroid Usage	<input type="checkbox"/> Headache	<input type="checkbox"/> Contacts/glasses
<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Unconscious	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Dentures
<input type="checkbox"/> Stroke/CVA/TIA	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chest Pain/Angina	<input type="checkbox"/> Bone/Joint Injury
<input type="checkbox"/> Heart Attack/MI	<input type="checkbox"/> Thyroid Prob.	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back Pain/Injury
<input type="checkbox"/> High Blood Press	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Head/Neck Injury
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Other:		

Explain all “YES” responses: _____

SURGERIES: _____

HOSPITALIZATIONS: _____

FAMILY HISTORY:

Mother: _____ **Alive?** ____ **Age** ____

Father: _____ **Alive?** ____ **Age** ____

Others: _____

SOCIAL HISTORY: Smoke/Tobacco Y/N Packs per day ____

Alcohol Y/N Drinks per day ____

FEMALE: Age at onset of Menses: ____ Last Period: ____/____/____ Regular?: Y/N