

Patient History and Information Database

Southern Bone & Joint Specialists

Name: _____
(Please Print Clearly)

Have you been seen by **any** Southern Bone & Joint physician in the last three years? Yes No

Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Sex: Male Female Marital Status: Married Single Divorced Widowed
Smoker: Yes No If yes, how much? _____ Average weekly alcohol intake: _____
Occupation: _____ Number of children: _____
Right or Left handed (circle) Allergies: _____

Medications: _____

Previous Surgeries: _____

Primary Physician: _____ Cardiologist: _____

Who can we thank for referring you to Southern Bone & Joint? _____
What is their relation to you? Doctor Friend Family Member Other

Please circle any conditions you have from the list below:

Respiratory: Asthma / Pneumonia / COPD / Emphysema / TB / Bronchitis / Chronic Cough / Collapsed Lung / Recurrent Sinusitis / Sleep Apnea / Home Oxygen

Oral: Loose Teeth / Infections / Recent Dental Procedures / Dental Procedures planned for near future

Cardiac: High Blood Pressure / Heart Disease / Heart Failure / Murmur / Pacemaker / Angina / Abnormal EKG / Rheumatic Fever / Mitral Valve Disease / Aortic Valve Disease / Chest Pain / Heart Rhythm Changes / Palpitations / Enlarged Heart / Blood Clots

GI: Ulcers / Hiatal Hernia / Reflux Disease / Cirrhosis / Jaundice / Hepatitis / Weight Loss or Gain / Difficulty Swallowing / Nausea / Vomiting / Diarrhea / Bleeding

Endocrine: High Blood Sugars / Diabetes – insulin / Diet Pills / Thyroid Disease / Adrenal Disease /

Neuro: Stroke / Seizure / Paralysis / Headaches / Migraine / Previous Head Injury / Polio / Multiple Sclerosis / Meningitis / Peripheral Neuropathy

Urinary: Kidney Failure / Dialysis / Kidney Stones / Incontinence / Painful Urination / Blood in Urine / Night Frequency / Recurrent Infections / Prostate Disease

Musculoskeletal: Rheumatoid Disease / Lupus / Sickle Cell Disease / Lyme's Disease / Gout

Misc.: Coumadin / Plavix / Warfarin / Ticlid / Cancer / Chemotherapy / Radiation / Insect or Tick Bites / Anemia / AIDS / HIV / Hemophilia / Pregnancy

Name: _____

Date: / /

What brings you to see us today?

Body part: _____ Side of body (circle): Right Left Both

When did it begin? _____ Is your problem due to an accident? Yes No

If yes, where did the accident occur? _____

Is this Worker's Compensation? Yes No

Type of pain (circle): Burning / Aching / Stabbing / Sharp / Dull

Duration of pain (circle): Constant / Hourly / Daily / Weekly / Monthly

Time course (circle): Getting better with time / Worsening / Staying the same

Does the pain radiate? Yes No If yes, where? _____

Any significant numbness or tingling? Yes No If yes, where? _____

Does it hurt at night? Yes No Does it awaken you? Yes No

What makes it worse? _____

What makes it better? _____

Circle any treatments/studies you've had regarding this problem: Other Orthopedic Consultations / Medications / Injections / Physical Therapy / Previous Surgery / X-rays / CT scans / MRI

List below any other treatments/studies you've tried regarding this problem:

****It is imperative that you bring actual copies of any films (X-rays, MRI scans, bone scans, or CT scans) with you to your appointment! Do not rely on the facility or referring physician to provide us with this information. Reports can be helpful but it is necessary for us to review the **actual** films to provide you with the best care possible. Also, bring any written records and/or operative reports regarding previous treatment. Having all relevant information so we fully understand the history of your orthopedic problem helps ensure you receive the best treatment.****

Please elaborate and/or add any pertinent information you feel may be helpful:
