

**PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.**  
**HISTORY FORM – NEW PATIENT**

Chief Complaint: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
W: \_\_\_\_\_ lbs H: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**FIELDS MARKED WITH AN ASTERISK (\*) ARE FEDERAL REQUIREMENTS.**

\*DOB: \_\_\_\_\_ \*Sex:  Male  Female \*Smoking:  Smoker  Nonsmoker  Former Smoker

**\*Current Medications, Vitamins & Supplements**

No Medications

Pharmacy | Location: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*Allergies (please list other drug allergies)**

None Known  Codeine  Iodine  Sulfa  Aspirin  Penicillin  Demerol  Adhesive/Tape

Other: \_\_\_\_\_

**Are your injuries related to:**

Auto accident  Work accident  School Athletic accident  Other accident  None

Attorney:  No  Yes (name, phone, address): \_\_\_\_\_  
\_\_\_\_\_

**Check off any diseases with which you were previously diagnosed**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Depression           | <input type="checkbox"/> Hypertension    |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Alzheimer's        | <input type="checkbox"/> Drug Abuse           | <input type="checkbox"/> Osteoarthritis  |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Eye Disease          | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Pacemaker       |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> GI Reflux            | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Sleep Apnea     |
| <input type="checkbox"/> Blood Clots        | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Strokes         |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> COPD               | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Ulcers          |

\_\_\_\_\_  Right Handed  Left Handed

**Orthopedic Surgeries (please include side and year)**

Arthroscopy: \_\_\_\_\_  Replacement: \_\_\_\_\_  
Side:  R  L Body Part: \_\_\_\_\_ Side:  R  L Body Part: \_\_\_\_\_  
 Spine: \_\_\_\_\_  Other: \_\_\_\_\_

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**Other Surgeries**

\_\_\_\_\_  
 \_\_\_\_\_

**Fractures**

\_\_\_\_\_  
 \_\_\_\_\_

**Have any of your family members ever been diagnosed with the following (members include, father, mother, sibling, grandfather, grandmother)?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Cancer: <input type="checkbox"/> Colon <input type="checkbox"/> Lung      | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Prostate | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's        | <input type="checkbox"/> Depression  | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Drug Abuse  | <input type="checkbox"/> Seizures       |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Gout  | <input type="checkbox"/> Liver Disease  |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Ulcers         |

**Social History**

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
**Marital Status:**  D  M  S  W **Retired:**   
**Pregnant:**  Yes  No **Disabled:**

**Alcohol**

- Drink alcohol  
 Do not drink alcohol  
 Former Alcoholic

**Illicit Drugs**

- User  
 Nonuser  
 Former User

**Caffeine**

- Drink caffeine  
 Do not drink caffeine

**Lifestyle**

Activity Level:  sedentary  moderate  vigorous  
 Exercise Freq.:  never  occasional  2-3x/week  3-4x/week  daily

List type of exercises or hobbies: \_\_\_\_\_

**Review of Systems – Have you had any problems with the following systems?**

<b>Nose / Throat</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Ears / Hearing</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Respiratory</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Cardiovascular</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Gastrointestinal</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Genital / Urinary</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Skin</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Neurological</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Optical / Eye</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Emotional</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Blood Disorders</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
<b>Glands</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____

