PATIENT INFORMATION

NORTHWEST BROWARD ORTHOPAEDICS

DATE: _____ ***E-MAIL ADDRESS: _____

(If e-mail address is not provided, you **MUST** write Patient denied.)

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Location_____

PATIENT NAME: _____

(LAST) (FIRST) (MIDDLE INITIAL)

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Home Address: _____

(NUMBER) (STREET) (APT#) (CITY) (STATE) (ZIP)

Home Telephone: _____ Work Telephone: _____

Cell Phone:_____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Divorced ☐ Child Custodial Parent:_____

Patient's Occupation: _____ Employed at: _____

Name of Primary Care Physician/Pediatrician: _____ Telephone: _____

Name of Referring Physician/Pediatrician:_____Telephone:_____

WHOM DO WE NOTIFY IN THE EVENT OF AN EMERGENCY: _____

Relationship: _____ Telephone: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ ID#: _____

Secondary Insurance Company: _____ ID#: _____

Subscriber Name: _____ Group Number: _____

Subscriber's Date of Birth _____

FINANCIAL INFORMATION:

IF PATIENT IS UNDER 18, PLEASE ENTER THE FOLLOWING INFORMATION:

NAME OF PARENT OR GUARDIAN RESPONSIBLE FOR THIS ACCOUNT: _____

Mother's Name: _____ Date of Birth: _____ SS#: _____

Mother's Work Telephone: _____ Occupation: _____

Father's Name: _____ Date of Birth: _____ SS#: _____

Father's Work Telephone: _____ Occupation: _____

ADDITIONAL PATIENT INFORMATION

PATIENT RACE AND ETHNICITY

PER STATE OF FLORIDA REQUIREMENT, PLEASE ELECT YOUR ETHNICITY FROM THE 3 CHOICES BELOW:

(NON-HISPANIC) (HISPANIC) (UNKNOWN)

PER STATE OF FLORIDA REQUIREMENT, PLEASE SELECT YOUR RACE FROM THE 10 CHOICES BELOW:

(ALASKA NATIVE) (AMERICAN INDIAN) (ASIAN) (BLACK) (NATIVE HAWAIIAN)

(NO RESPONSE) (OTHER PACIFIC ISLANDER) (OTHER) (UNKNOWN) (WHITE))

MEDICAL HISTORY

NAME _____ DATE_____

REASON FOR VISIT

_____

IS THIS DUE TO AN ACCIDENT OR INJURY? YES ___ NO ___ IF YES, WHEN? _____

HOW DID IT HAPPEN?_____

WHERE DID IT HAPPEN?_____

HAVE YOU BEEN TREATED FOR THIS PROBLEM BY ANYONE ELSE? YES ___ NO ___

IF YES, DATE _____ PLEASE LIST DR., HOSPITAL OR OTHER _____

AGGRAVATING SYMPTOMS

□ BENDING □ LIFTING □ STANDING □ WALKING
□ COUGHING □ SITTING □ TWISTING

WHAT HELPS RELIEVE YOUR SYMPTOMS?

□ BRACE □ ICE □ PHYSICAL THERAPY
□ HEAT □ MEDICATIONS □ REST

DO YOU HAVE ANY:

□ BUCKLING □ GIVING AWAY □ LOCKING □ SWELLING
□ CLICKING □ JOINT PAIN □ POPPING □ WEAKNESS

ALLERGIES:

□ ASPIRIN □ IODINE □ OR OTHER _____
□ SULFA □ PENICILLIN □ NO KNOWN ALLERGIES

CURRENT MEDICATION

□ **IF MULTIPLE MEDICATIONS PLEASE ATTACH A LIST**

OR CHOOSE FROM THE FOLLOWING LIST

□ NO MEDICATION
□ SIMVASTATIN
□ LISINOPRIL
□ PRILOSEC
□ ATENOLOL
□ OTHER: _____

□ OTHER: _____

PLEASE REVIEW AND COMPLETE ALL QUESTIONS BELOW. IF YOU NEED ANY ASSISTANCE, PLEASE ADVISE OUR OFFICE STAFF.

PAST MEDICAL HISTORY: (Please only check what applies)

- □ AIDS/HIV
- □ ANGINA
- □ ANXIETY
- □ ARTHRITIS
- □ ASTHMA
- □ ATRIAL FIBRILLATION
- □ BIPOLAR DISORDER
- □ BLOOD CLOTS
- □ BREAST DISORDER
- □ CANCER
- □ CHRONIC FATIGUE SYNDROME
- □ CHRONIC WOUNDS
- □ CONGESTIVE HEART FAILURE
- □ COPD EMPHYSEMA, BRONCHITIS
- □ DEPRESSION
- □ DIABETES, TYPE I OR TYPE II
- □ DVT (LEG CLOTS)
- □ FIBROMYALGIA
- □ GASTROINTESTINAL BLEEDING
- □ GLAUCOMA
- □ GOUT
- □ HEADACHES
- □ HEART DISEASE
- □ HEARTBURN/REFLUX
- □ HEPATITIS (A, B, C)
- □ HIGH BLOOD PRESSURE
- □ HIGH CHOLESTEROL
- □ INCONTINENCE
- □ KIDNEY STONES
- □ MACULAR DEGENERATION
- □ MI/HEART ATTACK
- □ OSTEOPOROSIS
- □ PNEUMONIA
- □ PROSTATE DISEASE
- □ PULMONARY CLOTS(LUNG CLOTS)
- □ SEIZURES
- □ STROKE
- □ STOMACH ULCERS
- □ THYROID DISEASE (LOW OR HIGH)
- □ URINARY TRACT INFECTIONS
- □ VALVE DISORDER

SURGICAL HISTORY (Please only check what applies)

- □ APPENDECTOMY
- □ BARIATRIC SURGERY
- □ BOWEL RESECTION
- □ BREAST SURGERY
- □ CARDIAC STENTS
- □ CATARACT REMOVAL
- □ CESAREAN SECTION
- □ COLONOSCOPY
- □ CORONARY ARTERY BY PASS GRAFT
- □ EAR TUBES
- □ ENDOSCOPY
- □ FRACTURE SURGERY
- □ GALLBLADDER SURGERY
- □ HEART VALVE REPLACEMENT
- □ HERNIA REPAIR
- □ HIP REPLACEMENT (RT/LT)
- □ HYSTERECTOMY
- □ KNEE ARTHROSCOPY (RT/LT)
- □ KNEE REPLACEMENT (RT/LT)
- □ LASIK
- □ ORTHOTIC/JOINTS
- □ PACEMAKER, CARDIAC
- □ PROSTATE SURGERY
- □ SHOULDER ARTHROSCOPY (RT/LT)
- □ SPINE SURGERY
- □ THYROIDECTOMY
- □ TONSILLECTOMY
- □ TUBAL LIGATION

TOBACCO USE/SMOKING

- □ CURRENT EVERYDAY SMOKER
- □ CURRENT SOMEDAY SMOKER
- □ FORMER SMOKER
- □ NONSMOKER

ALCOHOL SCREEN

HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

- □ NEVER
- □ MONTHLY OR LESS
- □ 2 TO 4 TIMES A MONTH
- □ 2 TO 3 TIMES A WEEK
- □ 4 OR MORE TIMES A WEEK

MARITAL STATUS

- □ SINGLE
- □ DIVORCED
- □ MARRIED
- □ WIDOWED
- □ NOT ANSWERED

FAMILY HISTORY

MOTHER ALIVE **OR** DECEASED
FATHER ALIVE **OR** DECEASED

(Please check all that apply to Family History)

- □ SCOLIOSIS
- □ DIABETES
- □ BREAST CANCER
- □ HIGH BLOOD PRESSURE
- □ COLON CANCER
- □ HEART DISEASE

REVIEW OF SYSTEMS

ALLERGY/IMMUNOLOGY
- ☐ ENVIRONMENTAL ALLERGIES
- ☐ FREQUENT INFECTIONS

ENT
- ☐ RINGING IN THE EARS
- ☐ NOSEBLEED
- ☐ DIFFICULTY SWALLOWING

ENDOCRINE
- ☐ HEAT OR COLD INTOLERANCE
- ☐ UNEXPECTED WEIGHT LOSS
- ☐ HAIR LOSS

RESPIRATORY
- ☐ SHORTNESS OF BREATH AT REST
- ☐ SHORTNESS OF BREATH WITH EXERTION

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ FLUID RETENTION
- ☐ LIGHTHEADEDNESS
- ☐ IRREGULAR HEARTBEAT

GASTROINTESTINAL
- ☐ ABDOMINAL PAIN
- ☐ NAUSEA
- ☐ VOMITING
- ☐ BLACK/TARRY STOOLS
- ☐ CONSTIPATION
- ☐ DIARRHEA

HEMATOLOGY
- ☐ LYMPHADENOPATHY
- ☐ EXCESSIVE BRUISING OR BLEEDING
- ☐ ANEMIA

GENITOURINARY
- ☐ FREQUENT URINATION
- ☐ BLOOD IN URINE
- ☐ URINARY URGENCY

MUSCULOSKELETAL
- ☐ MUSCLE SORENESS
- ☐ WEAKNESS
- ☐ SWELLING IN ARMS/LEGS

SKIN
- ☐ CHANGING MOLE(S)
- ☐ DRY SKIN
- ☐ ITCHING

NEUROLOGIC
- ☐ HEADACHE
- ☐ TINGLING/NUMBNESS

PSYCHIATRIC
- ☐ DEPRESSION
- ☐ ANXIETY

GENERAL CONSTITUTIONAL
- ☐ WEIGHT GAIN
- ☐ FATIGUE
- ☐ FEVER
- ☐ LOSS OF APPETITE
- ☐ CHILLS

I HAVE BEEN INSTRUCTED THAT IF I ANSWER YES TO ANY OF THE REVIEW OF SYSTEMS THAT DO NOT PERTAIN TO ORTHOPAEDICS, I MUST CONTACT MY PRIMARY CARE PHYSICIAN AND SEEK IMMEDIATE MEDICAL ATTENTION FOR THESE ISSUES.

NAME:_____

SIGNATURE:_____

DATE:_____

PLEASE MAKE SURE THAT ALL SECTIONS HAVE BEEN COMPLETED TO ENSURE PROPER PROCESSING

Northwest Broward Orthopaedic Associates, P.A.

Elliott W. Hinkes, M.D.*, F.A.A.O.S., F.A.C.S.

Bruce S. Fletcher, M.D.*, F.A.A.O.S., F.A.C.S.

Diplomates, American Board of Orthopaedic Surgery
**Fellowship Trained, Sports Medicine/Arthroscopic Surgery*

Date: _____

Patient: _____

I authorize Northwest Broward Orthopaedics to discuss my PHI, protected health information with the following people ***(e.g. SPOUSE, ADULT, CHILDREN, FRIEND, ATTORNEY etc...)***:

Please list name and phone#:

1. Name: _____

   Phone#: _____

2. Name: _____

   Phone#: _____

_____
(Patients Signature)

_____
(Witness)

_____
(Witness)

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