

Patient Signature

- NORMAN PALMERI, M.D.
- JOHN HRUSKA, M.D.

Date

- EDWARD ROSSARIO, M.D.
- GERALD SHUTE M.D.

(Please Print)

DATE: _____			REFERRING DOCTOR: _____			
PATIENT INFORMATION						
PATIENT'S LAST NAME		FIRST	MI:	<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS <input type="checkbox"/> MS.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name? _____		DOB: _____	Age: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address: _____			Social Security no.: _____		Home phone no.: () _____	
City _____		State _____		ZIP Code: _____	Alternative Phone # (cell) _____	
Employer: _____		Employer Address: _____		Employer phone no.: () _____		
How were you referred: (Please check one ox):			<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Phonebook	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Family
<input type="checkbox"/> Friend: Name: _____		Hospital: SLMC OR LPMC		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other _____	
Please list any person/s that we may speak with about your healthcare. You may at any time with written authorization change or revoke this authorization. By completing this section, you authorize the following person/s to discuss all your health care needs, billing issues and or questions.						
1. _____		2. _____		3. _____		

INSURANCE INFORMATION	
(Please present your drivers license and your insurance card/s to the receptionist.)	
PRIMARY INSURANCE: _____ POLICY # _____ GROUP# _____	
NAME OF INSURED: _____ DOB _____ SSN# _____	
SECONDARY INSURANCE: _____ POLICY # _____ GROUP# _____	
NAME OF INSURED: _____ DOB _____ SSN# _____	
Is the <u>Primary</u> insurance listed above provided by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list employers name. Name of Employer: _____	
Is the <u>Secondary</u> insurance listed above provided by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list employers name. Name of Employer: _____	
RESPONSIBLE PARTY INFORMATION (If Minor)	
Last Name: _____ First Name: _____ MI _____ DOB _____	
Address: _____ Home # _____ Work # _____	
Relationship to Patient _____	
IN CASE OF EMERGENCY	
Name of local friend of relative (not living at the same address) Home # _____ Work # _____	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Coastal Orthopaedic & Sports Medicine Center or insurance company to release any information required to process my claims.	
Patient Signature (<i>parent if minor</i>) _____ Date _____	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name : _____
LAST FIRST M F AGE _____
MI

Marital Status: Single Married Separated Divorced Widowed

Referring Doctor: _____ Height: _____ Weight: _____

Occupation: _____

PERSONAL HEALTH HISTORY

REASON FOR VISIT:

DATE OF INJURY:

Is your injury Work Related Yes No

Is your injury Auto Related Yes No

Have you had any recent X-rays or MRI studies? Yes No

Have you previously been treated for this problem? Yes No

Were you treated in the emergency room? Yes No

If Yes, Which One St. Lucie Medical Center Lawnwood Regional Other

Are you represented by an Attorney? Yes No

If Female: Are you pregnant? Yes No

HISTORY (please check)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neck/Back Disorder | <input type="checkbox"/> TB Other |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other: List Below |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phlebitis | |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Stroke/TIA | |

REVIEW OF SYMPTOMS

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Addiction: | <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Cold/Heat Intolerance | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Abnormal Heartbeat | <input type="checkbox"/> Calf Cramps | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Extremity Numbness |
| <input type="checkbox"/> Burning on Urination | <input type="checkbox"/> Chills or Fevers | <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart/Chest Pain | <input type="checkbox"/> Leg Skin/Ulcers | <input type="checkbox"/> Prior Risk of Anesthesia | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Intestinal Bleeding | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Shortness of Breath | |

HISTORY CONTINUED ON NEXT PAGE

SOCIAL HISTORY

Right Handed Left Handed Do you live Alone? Yes No

Do you Smoke? Yes No Never Quit Date _____

Do you use Alcohol? Yes No How often? Socially Moderate to Heavy

History of Drug Abuse? Yes No How Often? Presently Past

Do you exercise? Yes No List your Interest or Hobbies: _____

PREVIOUS SURGERIES

Tonsils Gallbladder Appendix Prostate Hysterectomy Cancer

Back Cervical Lumbar Fracture

Other List: _____

FAMILY HISTORY

Has a member of your family had a history of any of the following conditions?

Stroke Heart Disease Arthritis Gout Seizures Cancer

Mental Illness Kidney Disease or Stones Bleeding Disorders Alcoholism Addiction

HIV/Aids Leukemia Hypertension Other: _____

Explain all Yes Answers: _____

LIST OF CURRENT MEDICATIONS, DOSAGES AND FREQUENCY

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATION

NAME OF DRUG	REACTION YOU HAD

PATIENT SIGNATURE: _____ DATE: _____