Name:
Chart:
Date:

PIEDMONT ORTHOPEDIC PATIENT HISTORY FORM

Patient Name _____ Today's Date _____

Date of Birth _____ Age _____ Height _____ Weight _____

Name of Referring Doctor _____

Name of Primary Doctor _____

CURRENT MEDICATIONS AND DOSAGE

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

DRUG OR FOOD ALLERGIES _____

PREVIOUS SURGERIES OR HOSPITALIZATIONS WITH DATES

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

FAMILY MEDICAL HISTORY (What major illnesses have run in your family?)

Diabetes _____ Heart Disease _____ Lung Disease _____
Cancer _____ Type of Cancer _____
High Blood Pressure _____ Other _____

SOCIAL HISTORY

Marital Status: (circle one) Married Single Divorced Widow/Widower Separated
If married, what is the name of your spouse? _____
Your Occupation _____ Do you smoke cigarettes: Yes / No
If yes, how many years have you smoked? _____ How many packs smoked daily? 1/2 1 more than 2
If no, but you quit smoking, how many years did you smoke? _____ How many packs were smoked daily? 1/2 1 more than 2
Do you drink alcohol? Yes / No (circle one) How often do you drink alcohol?

PLEASE CHECK WHICH OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

_____ Acid reflux
_____ Aids
_____ Alcoholism
_____ Anxiety
_____ Arthritis
_____ Asthma
_____ Bladder Problems
_____ Bleeding Disorders
_____ Bronchitis
_____ Cancer
_____ Cataracts
_____ Depression
_____ Diabetes
_____ Drug Dependency
_____ Emphysema
_____ Epilepsy
_____ Glaucoma
_____ Goiter
_____ Heart Disease
_____ Hepatitis
_____ High Blood Pressure
_____ HIV Positive
_____ Kidney Disease
_____ Liver Disease
_____ Migraines
_____ Mononucleosis
_____ Multiple Sclerosis
_____ Osteoporosis
_____ Pace Maker
_____ Pneumonia
_____ Polio
_____ Prostate Problem
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Stroke
_____ Teeth/Gum Disease
_____ Thyroid Problems
_____ Tuberculosis
_____ Ulcers
_____ SLEEP APNEA

OTHER: _____

Name:
Chart:
Date:

Authorization to release PHI (Personal Health Information)

I hereby authorize Southeastern Orthopaedic Specialists, P.A. to release my PHI to:
(EXCLUDES PHYSICIANS & ATTORNEYS)

Name of person that information may be released to:
(i.e. spouse, parent, guardian, sibling, etc.)

Address

Patient's Name: _____ Date of Birth: _____

Address: _____

Patient's Signature: _____ Date: _____

Relationship to Patient: _____

Type of information that may be released:
(financial, medical information, information for a specific problem)

Expiration Date: _____

To revoke this authorization, it must be submitted in writing to Southeastern Orthopaedic Specialists, P.A.

There is potential for re-disclosure once this information is disclosed. SOS cannot control what the other entity does with your PHI (Personal Health Information).