

PALM BEACH SPORTSMEDICINE AND ORTHOPAEDIC CENTER, P.A.

CLINICAL PATIENT INFORMATION SHEET

Print CLEARLY and leave no blank spaces

Chart #: _____

Patient Name: _____

Name of Primary Care/Family Physician (if any):

Phone #: _____

COMPLAINT: _____

If seen in an emergency room, name of hospital:

Have you been treated by another doctor?

____ Yes ____ No

Name of other doctor: _____

Do you smoke? ____ yes ____ no Packs per day = _____

Date you stopped smoking ____/____/____

Do you drink? ____ yes ____ no Drinks per day = _____

Do you use drugs? ____ yes ____ no

Have you ever used drugs ____ yes ____ no

If yes, date stopped ____/____/____

Have you had a history of the following:

- ____ Yes ____ No Glaucoma
- ____ Yes ____ No Diabetes
- ____ Yes ____ No Thyroid disease
- ____ Yes ____ No High blood pressure
- ____ Yes ____ No Lung disease
- ____ Yes ____ No Heart disease
- ____ Yes ____ No Stomach ulcer
- ____ Yes ____ No Recent infections
- ____ Yes ____ No Cancer (type) _____
- ____ Yes ____ No HIV Positive (AIDS)
- ____ Yes ____ No Hepatitis B

Any other medical problems? _____

Current status: Check one only

YES NO

Are you married? _____

Are you divorced? _____

Do you live alone? _____

Are you a widow(er)? _____

Date of injury: ____/____/____

Briefly describe how injury happened:

List all medications you are taking at this time: None

List any medications you are allergic to: None

List all operations you have had: None

Has any member of your family had a history of the following:

- ____ Yes ____ No Glaucoma
- ____ Yes ____ No Diabetes
- ____ Yes ____ No Thyroid disease
- ____ Yes ____ No High blood pressure
- ____ Yes ____ No Lung disease
- ____ Yes ____ No Heart disease
- ____ Yes ____ No Stomach ulcer
- ____ Yes ____ No Recent infections
- ____ Yes ____ No Cancer (type) _____
- ____ Yes ____ No HIV Positive (AIDS)
- ____ Yes ____ No Hepatitis B

Upon agreement between the Patient (and/or Responsible Person) and the treating Physician, I hereby authorize the Physicians of Palm Beach SportsMedicine and Orthopaedic Center, P.A. to administer such Medical Care as may be deemed advisable in diagnosis and treatment of the Patient.

Patient Signature: _____ Date: _____

(Or legal guardian, if minor or patient incapacity)