

Jacksonville Orthopaedic Institute
PATIENT HISTORY – Complete using BLACK INK

Patient Name: _____ Age _____ DOB _____ Height _____ Weight _____

HISTORY OF PRESENT ILLNESS

Male Female Hand Dominant: Right Left

Primary Care Physician _____ Phone: _____

Who referred you to JOI ? _____ Other _____

Area(s) that need treatment _____

Circle One: Is this: WORK AUTO OTHER _____ Date of Injury/Onset of Pain ____/____/____

Explain how and where this problem / injury occurred and symptoms: _____

Have you been treated by any other physician and/or hospital for **THIS** problem? YES NO

If yes, what type of treatment or surgeries were performed? _____

By whom? _____ When? _____

Previous injury to this area? YES NO If YES, when? _____

PAST MEDICAL HISTORY:

Date of Last Tetanus: ____/____/____

Medical Conditions: _____

Surgeries: (all) _____

ROS: Have you ever had any problems with the items below? Please circle YES or NO to all. (If yes, please explain on back of sheet)

Weight loss/gain	YES	NO	Eyes	YES	NO	Stomach/abdomen	YES	NO
Heart	YES	NO	Lungs	YES	NO	HIV/AIDS	YES	NO
Skin	YES	NO	Memory Loss	YES	NO	Urinary	YES	NO
Other bones/joints	YES	NO	Kidney	YES	NO	Free bleeding	YES	NO
Diabetes	YES	NO	Seizures/fits	YES	NO			
Hepatitis	YES	NO	Mouth/throat	YES	NO			

Medications: _____

List all allergies: _____

FAMILY HISTORY: Does anyone in your family have? ADOPTED YES NO

Cancer	YES	NO	Diabetes	YES	NO	Thyroid Disease	YES	NO
Stroke	YES	NO	Heart Problems	YES	NO	High Blood Pressure	YES	NO

SOCIAL HISTORY:

Do you Smoke? YES NO Amount/day _____ Drink Alcohol? YES NO Amount / week _____

Marital Status? _____ Level of Education _____ Occupation _____

Place of Employment _____ How long? _____

Patient Signature Date ____/____/____

MD: _____
Date: _____