KEY WEST ORTHOPEDICS
3428 North Roosevelt Boulevard
Key West, Florida 33040
Robert Catana, D.O. David C. Perry M.D.

20___ PATIENT HISTORY FORM

Patient's Name:_____ Referred by? _____

What is the reason for your visit?_____

What is your profession?_____ Are you right or left handed?_____

Is your visit the result of an injury? Yes or No

Date of Injury:_____ Place of Injury:_____

City and State:_____ Describe your injury:_____

_____

If you did not have an injury, how long have you had symptoms?_____

What treatment(s) have you had for this problem, and has it helped?_____

Was this Work Related? YES or NO

Claim Number:_____

Adjuster's Name:_____ Address:_____

_____

Phone:_____ Fax:_____

Was this Auto Related? YES or NO

Claim Number:_____ Adjuster's Name:_____

Address:_____

Phone: _____ Fax:_____

Do you have an Attorney for the above injury? YES or NO

Name:_____ Address:_____

_____

Phone:_____ Fax:_____

MEDICAL HISTORY Please check all that apply and or list your medical problems:

_____ High Blood Pressure	_____ Diabetes	_____ Heart Disease	_____ Cancer
_____ Blood Clots	_____ Gout	_____ Ulcers	_____ Irregular heart beat
_____ Stroke	_____ Arthritis	_____ Osteoporosis	_____ Kidney Disease

Additional Information:_____

SURGICAL HISTORY Check all that apply and or list your previous surgeries:

_____ Hip Replacement	_____ Knee Replacement	_____ Arthroscopy
_____ Shoulder/Rotator Cuff	_____ Fracture Surgery	_____ Appendix
_____ Gallbladder	_____ Prostrate	_____ Pacemaker
_____ Hysterectomy	_____ Caesarian Section	

Additional Information:_____

FAMILY HISTORY

Mother: _____Alive _____Deceased _____Unknown _____Healthy
Medical History:_____

Father: _____Alive _____Deceased _____Unknown _____Healthy
Medical History:_____

MEDICATIONS

List your present medications and supplements along with doses and frequency:

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

ALLERGIES

Are you allergic to any medications? YES or NO

If yes, please list and describe what happens:_____

OTHER HISTORY

Do you smoke?_____ Number of years?_____ How much per day?_____
Have you ever smoked?_____ When & why did you stop?_____
Do you drink alcohol?_____drinks per day_____ per week_____
Do you have a history of substance abuse? Never_____ Present_____ Past_____

Height:_____ Weight:_____ Age:_____

REVIEW OF SYSTEMS Do you have any of the following problems? Please circle YES or NO to the following:

What is your current pain level: 0 1 2 3 4 5 6 7 8 9 10
(Please circle your current pain level 0 being least and 10 being highest)

Unexpected weight change	YES	NO	Difficulty Urinating	YES	NO
Chills	YES	NO	Burning with Urination	YES	NO
Fevers	YES	NO	Do you feel depressed	YES	NO
Tremors	YES	NO	Are you claustrophobic	YES	NO
Dizzy Spells	YES	NO	Bone Pain	YES	NO
Numbness/Tingling	YES	NO	Joint Pain	YES	NO
Double vision	YES	NO	Muscle Pain	YES	NO
Glaucoma	YES	NO	Excessive Thirst	YES	NO
Hearing Problems	YES	NO	Too Hot/Cold	YES	NO
Sore Throat	YES	NO	Tired/Sluggish	YES	NO
Sinus Infections	YES	NO	Excessive Bleeding	YES	NO
Chest Pains	YES	NO	Bruise Easily	YES	NO
Palpitations	YES	NO	Leg pain w/walking	YES	NO
Wheezing	YES	NO	Leg pain at rest	YES	NO
Frequent Cough	YES	NO	History of Blood Clots	YES	NO
Shortness of Breath	YES	NO	Do you have a rash anywhere on your body at this time?_____		
Abdominal pain	YES	NO	Have you ever had a bone density scan done for osteoporosis?_____		
Nausea/Vomiting	YES	NO	If yes, how long ago?_____		