



GULF COAST ORTHOPEDICS

A Division of Houma Orthopedic Clinic, AMC

Thank you for choosing Gulf Coast Orthopedics. We are committed to providing you with quality and comprehensive orthopedic care. Please help us by completely filling out all of the information below. We will keep this information confidential and only release it only with your consent. If you need assistance filling out this form please notify the receptionist.

Demographics

Please print all information.

Patient's Name:		Today's Date:	
Race: (Please circle) Hispanic American Indian Asian Black/African American White Other:			
Ethnicity: (Please circle) Hispanic or Latino Not Hispanic or Latino Unknown by patient			
Sex: (circle one) Male Female	Date of Birth:	Language: English / Spanish	Age:
Address:		Mailing Address:	
City:		State:	Zip Code:
Social Security Number:			
Home Telephone:		Work Telephone:	Cell Telephone:
If a minor, name of guardian and relationship:		email Address:	

Notify in Case of Emergency

Name:		Relationship:
Home Telephone:	Work Telephone:	Cell Telephone:

Billing Information

Who is Responsible for the bill?	
Workers Compensation	☐ Company Name: _____
Primary Insurance Company	☐ Insurance Company: _____
Insurance Address, City, State, Zip: _____ Telephone Number: _____	
Name of Insured: _____ Insured Date of Birth: _____	
Contract or Policy Number: _____ Group Number: _____	
Secondary Insurance Company ☐ Company Name: _____	
Insurance Address, City, State, Zip: _____ Telephone Number: _____	
Name of Insured: _____ Insured Date of Birth: _____	
Contract or Policy Number: _____ Group Number: _____	
Self Payment ☐	
Attorney ☐ Name & Phone Number: _____	

Employment History

Are you currently employed? Yes ☐ No ☐ Name of Employer: _____ What is your job title: _____	
Occupation: _____	

Signature: _____ Date: _____

Patient Name: _____

Social History

Are you: Single ☐ Married ☐ Divorced ☐ Widowed ☐			
Living Arrangements: Home alone ☐ Home with Spouse ☐ Assisted Living ☐ Nursing Home ☐			
Do you presently smoke tobacco? Yes ☐ No ☐ If no, have you ever smoked Yes ☐ No ☐ When did you quit?			
If yes, please list the amount you smoke _____ pack / day _____ packs / week _____ Number of years smoked			
Do you drink alcohol regularly? Yes ☐ No ☐			
If yes, please list the amount and type ingested per day: _____			
Pharmacy/Location _____		Cardiologist _____	
Home Health _____		Physical Therapist _____	

Problem

What are you seeing the doctor for today? _____

How long have you had these symptoms: _____

Date of accident or injury: _____

Where did it occur? _____

How did the accident happen? _____

Who, if anyone, has been treating you for this problem? _____

What treatment, if any, have you had? _____

Have you had any x-rays for this problem? _____

When? _____ Where? _____

Have you had a CT Scan, Myelogram or MRI for this problem? _____

When? _____

Where? _____

Nerve Study _____ When? _____

Where? _____

Referring Physician _____

Medications

Drug	Dosage	Drug	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Allergies

Do you have a history of latex allergy? Yes ☐ No ☐

Drug	Reaction	Drug	Reaction
1.		6.	
2.		7.	

Patient Name _____

Past Medical History

Illness / Injury	Yes	No	Illness / Injury	Yes	No
High blood pressure			Kidney disease		
Diabetes			Liver disease		
Heart attack			Females ONLY: Are you or could you be pregnant?		
Chest pain or angina			AIDs or HIV Infection		
Stroke			Thyroid problems		
Cancer			Shortness of breath		
Hepatitis			Blood Clots		
Stomach Ulcers			Bleeding tendency		
Arthritis			Accidents / Broken bones (please list)		
Gout					
Anesthetic complications					

Past Surgical History

Year	Name of Operation	Type of Anesthetic (general, regional, local)	Complications

Family Medical History (Do you have a family history of any of the following illnesses?)

Illness	Yes	No	Illness	Yes	No
Cancer			Rheumatoid Arthritis		
Heart Disease			Degenerative Arthritis		
High Blood Pressure			Thyroid Disease		
Diabetes			Immune Disorders		

Review of Systems

	Yes	No		Yes	No		Yes	No
Constitutional Symptoms			Gastrointestinal			Neurological		
Recent weight change			Loss of appetite			Frequent headaches		
Fever			Nausea or vomiting			Light headed or dizzy		
Unexplained sweating			Frequent diarrhea			Seizures		
Eyes			Constipation			Numbness or tingling		
Wear glasses or contacts			Rectal bleeding or blood in stool			Tremors		
Blurred or double vision			Black tarry stools			Paralysis		
Glaucoma			Regular abdominal pain or heartburn			Psychiatric		
ENT			Genitourinary			Memory loss or confusion		
Hearing loss			Frequent urination			Anxiety		
Regular nose or gum bleeding			Burning or painful urination			Depression		
Sore throat			Blood in urine			Insomnia		
Swollen glands in neck			Incontinence or dribbling			Endocrine		
CV			Female:# of pregnancies			Glandular or Hormone Problem		
Irregular heart beats			Female:# of miscarriages			Excessive thirst or urination		
Shortness of breath w/walking or lying flat			Musculoskeletal			Heat or cold intolerance		
Swelling in feet, ankles, and hands			Joint pain			Changes in hair or nails		
Fainting spells			Joint stiffness and swelling			Hematology		
Elevated cholesterol			Morning stiffness			Bruising tendency		
Respiratory			Difficulty walking			Amnesia		
Chronic or frequent coughing			Muscle cramping			Need for past transfusion		
Spitting up blood			Integumentary					
Regular shortness of breath			Rash or itching			Height		
Emphysema			Changes in skin color			Weight		
Regular wheezing			Varicose veins					

I certify that to the best of my knowledge the preceding information is true and accurate.

Patient Signature (or parent if patient is a minor) _____

_____ Date

Patient's Name: _____

Using the following symbols, please mark all the appropriate areas of your body that are affected by the corresponding sensations:

ACHING

++++++

++++++

NUMBNESS

PINS & NEEDLES

0000000000000000

0000000000000000

BURNING

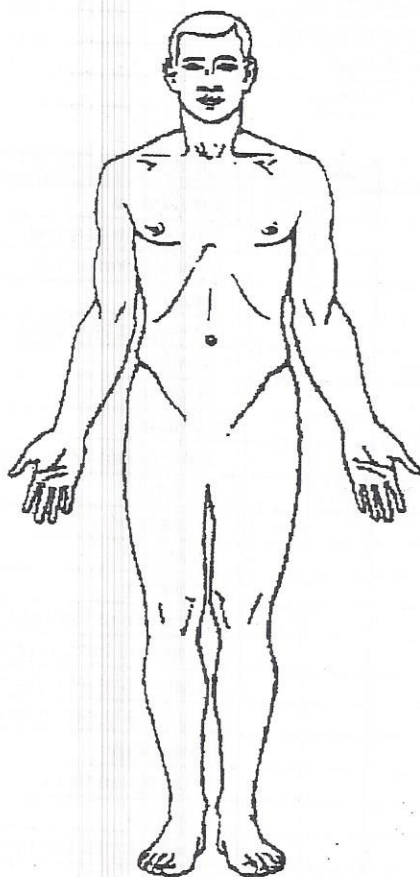
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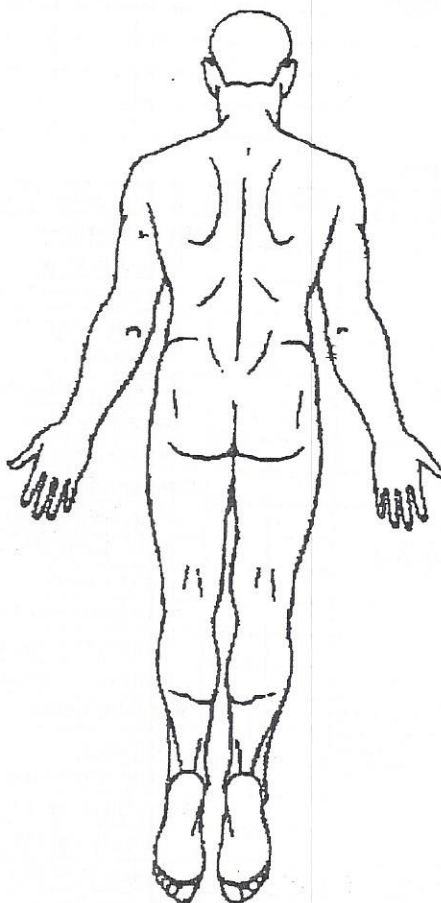
STABBING

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FRONT



BACK