ROPER
ST. FRANCIS
PHYSICIAN PARTNERS

PATIENT INFORMATION

Name: ________________________________ **Date**: _________________ **DOB:** ________________

Referring Provider: _______________________ **Other Treating Providers:** _______________________

CURRENT MEDICAL CONDITIONS:

Please list any known medical conditions (cardiac, pulmonary, cancer, diabetes, etc.)

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PAST MEDICAL HISTORY:

Please list any hospitalizations, operations, procedures, any complications related to the surgery or procedure.
For any listed operations or procedures, please include the date it was performed.

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FAMILY HISTORY:

Please list any known medical conditions of your immediate family members (mother, father, siblings, etc.)

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SOCIAL HISTORY:

Are you currently employed? YES NO If yes, occupation? ____________________________________

What physical activities do you do on a regular basis? _________________________________

Do you currently smoke? YES NO If yes, how much and how long? __________________________________

Did you ever smoke? YES NO If so, how long and when did you quit? __________________________________

Do you consume alcohol? YES NO If yes, how much and how long? ______________________________

ADVERSE AND ALLERGIC REACTIONS

Please list all allergies. If you have had a reaction to a medication, list the name and type of reaction.

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MEDICATIONS CURRENTLY TAKING

Please list all medications. Include the name of medication, dose & frequency, and reason for taking the medication.

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REASON FOR VISIT:

Is your reason for visit related to an injury? YES NO

Date of injury: ___________________________ Work related? YES NO

Was your injury related to an automobile accident? YES NO

How did the injury occur? ____

Where did the injury occur? ____

______________________________________ ______________________________

PATIENT/GUARDIAN SIGNATURE **DATE**