

Date: _____

FLORIDA ORTHOPAEDIC INSTITUTE

New Patient Health History

*Welcome to Dr. Herscovici's office. In order to effectively treat you, it is necessary that we obtain a complete medical history. Please fill out all areas of this form leaving no blanks. If an item does not apply to you, write "NA" in that section.
If you need help, ask one of the staff.*

Age: _____ Height: _____ Weight: _____ Referring Physician: _____

Name: _____ Occupation: _____

Problem/Injury: (Right/Left) _____

Date of Onset/Injury: _____ Work Related? (YES / NO) _____

Past Medical History & Review of Systems (Circle all that apply)

- | | | | |
|---------------------|----------------------|---------------------------|----------------------------------|
| Heart Disease | Rashes | Indigestion/Ulcers | Difficulty Sleeping |
| High Blood Pressure | Headaches | Psychiatric Problems | Hematologic/Lymphatic |
| Asthma | Epilepsy/Convulsions | Arthritis | Diabetes |
| Coughing | Eyes | Kidney/Bladder Infections | Thyroid |
| Pneumonia | Ears/Hearing | Excessive Wt loss/Gain | Fever/Chills/Unusual Weight Loss |

Other (List): _____

Medications: (Continue on back if necessary)

Medication	Dosage (mg or %)	How Often	For What Purpose

Allergies: _____ Health Habits: _____

Tobacco (Y / N): Amount _____

Alcohol (Y / N): Amount _____

Family History: _____ Children: (Y / N) Ages _____

Diabetes (Y / N) _____ Other: _____

Heart Disease (Y / N) _____

Cancer (Y / N) _____

Past Surgical History: (Continue on Back if necessary)

Date	Procedure	Hospital	Outcome

Sports: _____

Hobbies: _____

Patient Signature

Physician Reviewer

