Dear Patients,

This letter is being given to you in reference to your office visit and post-operative follow-up visits with our clinic and during your hospital stay.

My role in this community, as an Orthopaedic Surgeon, has always been to provide the best care for my patients in a timely and efficient manner.

During your office visit or hospital stay, Austin Thompson and Nicole Ploger my Physician Assistants, and I will be providing you with appropriate, efficient and personalized care. Having a qualified physician assistant on our staff and following your progression while in the hospital, provides you with continuity of care and allows me to offer my expertise and counseling to our other patients in need.

Austin Thompson and Nicole Ploger are part of our medical staff and has been trained in the field of Orthopaedic surgery. As an extension of myself they are able to monitor your hospital stay and address any questions or concerns in a timely manner. On days that I do not see you, Austin/Nicole and I will discuss your case thoroughly. Additionally, I personally supervise the care plans implemented and assure that the highest level of professional health care is delivered. If you are a new patient to see me and I am not here on that day, please request to see me on your follow up visit. We will try to make that happen without you asking, but if we fail to do this please notify our scheduler (813) 633-5232 extension: 6533 and have it rectified.

By working as, a team, we are able to help more patients in a timely fashion, eliminate the necessity to reschedule patient appointments, and most importantly, provide the best patient care possible.

Thank you.

Sincerely,

Anthony F. Infante Jr.,

Appointments: 813-978-9797 • General Information: 813-978-9700
Urgent Care: 813-FL-ORTHO (813-356-7846)
www.floridaortho.com
FLORIDA ORTHOPAEDIC INSTITUTE
ANTHONY INFANTE, D.O. • AUSTIN THOMPSON, PA-C • NICOLE PLOGER, PA-C
PATIENT QUESTIONNAIRE
INITIAL EVALUATION

Date: __________________________________________

Patient Name: ____________________________________

Address: _______________________________________

Family/Primary Doctor: ____________________________

Family/Primary Doctor’s Address: ______________________

Who referred you to Florida Orthopaedic Institute? ○ Friend ○ Physician ○ ER ○ Former Patient ○ Patient

Name: _________________________________________

INSTRUCTIONS: Please complete the follow questionnaire before you see the doctor Circle the word or phrase that best describes your situation. You may select more than one answer per question. Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. Thank you.

Age: _______ Sex: _______ Marital Status: _______ Handed: Right / Left

Height: _______ Weight: _______ Occupation: ________________________________

What are you seeing the doctor for? _________________________________________

HISTORY OF PROBLEM/INJURY

When did the problem first start?: ____________________ Duration of symptoms: _________________

Is this an injury? __________ Auto-related? __________ Work-related?: __________

Have you seen a doctor in the past for this problem or injury? If yes, when and who?

Explain in your own words how this injury occurred: ________________________________

What treatment have you had? Please list and circle below:

○ Injection ○ Aspiration ○ Physical Therapy ○ Exercise ○ Anti-inflammatory medication ○ Pain medication

○ Chiropractic care ○ Bracing ○ Heat/Ice ○ Massage ○ Rest ○ Other: _______________________

Have you received non-surgical for at least 3 months for this problem? ○ Yes ○ No

By whom? ______________________________________

1
Please circle any anti-inflammatory medications that you have taken in the past. Please include all prescription, over-the-counter, and sample medications.

Advil  Ibuprofen  Lodine  Naproxen  Tylenol  Ultram  Duexis  Vimovo
Diclofenac  Pennsaid Gel  Voltaren Gel  Mobic/Meloxicam  Celebrex  Indocin  Relafen

Please circle any side effects you have had from any of the previous anti-inflammatory medications:
Nausea  Diarrhea  Ulcers  Vomiting  Other: ________________________________

Would you be interested in taking part in a research study?  Yes/No

MEDICAL HISTORY

Please circle any of the following medical problems listed below that you are currently being treated for:

- I have no known medical problems
- High blood pressure (Hypertension)
- Low blood pressure (Hypotension)
- Coronary Artery Disease/ Heart Disease
- Peripheral Vascular disease
- Diabetes (High blood sugar/ Hyperglycemia)
- Low blood sugar (Hypoglycemia)
- Previous heart attack (myocardial infarction)
- Asthma
- Stomach bleeding (ulcers)
- Hepatitis A/B/C (circle one)
- HIV
- Cancer
  - Type: ________________________________
  - When: ________________________________
  - Treatment: ________________________________
- Overweight (obesity)
  - Body part: ________________________________
  - When: ________________________________
  - Treatment: ________________________________
- Blood clot (DVT); when: ________________________________
- Irregular Heartbeat: ________________________________
- Arthritis: ________________________________
- Neuropathy/Nerve pain: ________________________________
- Other: ________________________________
SURGERIES Circle any surgeries listed below you may have had. Please indicate the year of surgery, if available.

- No previous surgeries
- Arthroscopy
  - Knee R/L  Shoulder R/L  Hip R/L
- Appendectomy (Removal of Appendix)
- Cataracts
- Heart Surgery
  - Catherization  Bypass  Stent  Ablation
- Fracture repair
- Gallbladder Removal
- Hernia Repair
- Tonsillectomy
- Cancer
- Hysterectomy
- Joint Replacement
- Knee R/L  Shoulder R/L  Hip R/L
- Other joint: 
- Spine Surgery
  - Cervical (neck)
  - Thoracic (middle back)
  - Lumbar (low back)
- Vascular Surgery
- Mastectomy (Breast)
- Prostate
- Other:

MEDICATIONS

Please list ALL medications you are currently taking, including over the counter.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency (# of times a day)</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Are you currently taking any pain medications not listed above? ________________________________________________________________________

Are you currently taking any of the following on a regular basis? (Please circle all that apply)

- Aspirin
- Coumadin
- Pradaxa
- Eliquis
- Heparin
- Fish Oils
- Plavix
- Lovenox

If so, for what reason: ________________________________________________________________________

PLEASE PROVIDE PHARMACY NAME: __________________________ PHONE NUMBER: __________________________

LOCATION: __________________________ FAX NUMBER: __________________________
ALLERGIES

Please circle anything below that you are allergic to (please include reaction if known):

- No known allergies
- Penicillin; reaction: _____________________________
- Tetracycline; reaction: _____________________________
- Sulfa; reaction: _____________________________
- Morphine; reaction: _____________________________
- Erythromycin; reaction: _____________________________
- Codeine; reaction: _____________________________
- Hydrocodone (vicodin/Lortab/norco); reaction: _____________________________
- Percocet (Oxycodone); reaction: _____________________________
- NSAIDs (anti-inflammatories); reaction: _____________________________
- Iodine/Betadine; reaction: _____________________________
- Radiographic dyes/Contrast; reaction: _____________________________
- Shellfish; reaction: _____________________________
- Latex; reaction: _____________________________
- Adhesive Tape; reaction: _____________________________
- Metals
  - Nickel; reaction: _____________________________
  - Titanium; reaction: _____________________________
  - Platinum; reaction: _____________________________
  - Other; reaction: _____________________________
  - Other: _____________________________

Do you see an allergist for any of your allergies listed above?  Yes  No

If so, who: _____________________________
FAMILY MEDICAL HISTORY

Has anyone in your immediate family ever been diagnosed with any of the following? (Please circle all that apply)

○ No known  ○ Adopted  ○ Heart Disease  ○ Alcoholism
○ Cancer; Type: _____________  ○ Diabetes (High blood sugar)  ○ Immune Disorder; Type: _____________
○ Leukemia  ○ Thyroid Disorder  ○ Bleeding Disorder; Type: _____________
○ Stroke  ○ Asthma  ○ Drug abuse
○ High Blood pressure (Hypertension)  ○ Seizure Disorder  ○ High Cholesterol

SOCIAL HISTORY

Do you consume alcohol?  Yes  No

If so, how much?  ○ 1-2 drinks per day  ○ 2-3 drinks per day  ○ 1-2 drinks per month  ○ Socially

Do you smoke or have you ever smoked?  Yes  No

○ Currently a smoker: _____ packs a day ______ years

○ Former Smoker: _____ packs a day ______ years  Quit: _____________

Do you now or have you ever used drugs?  Yes  No

○ Recreational  ○ Marijuana  ○ Cocaine  ○ Other: _____________

REVIEW OF SYSTEMS

Do you have any of the following symptoms (Please mark yes or no for all that apply)

SYMPTOMS

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dry cough</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Productive Cough</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty Breathing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Irregular Heartbeat</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Swelling in the legs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Lack of Appetite</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nausea</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nose Bleeds</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Joint pain</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Joint Stiffness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Muscle pain</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Muscle stiffness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty Seeing</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Difficulty hearing</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Difficulty swallowing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty sleeping</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Other: ____________________________
<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
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<tr>
<td>Constipation</td>
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<td></td>
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<tr>
<td>Abdominal Cramping</td>
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<tr>
<td>Varicose Veins</td>
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</tr>
<tr>
<td>Bruising</td>
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<tr>
<td>Bleeding</td>
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</tbody>
</table>

EVERYTHING I HAVE ANSWERED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

__________________________________________
Patient Signature

THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE. IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD AT FLORIDA ORTHOPAEDIC INSTITUTE.