



8100 S. Walker – Building A, Oklahoma city, Ok 73139

Phone (405) 632-4468 Fax (405)632-0436

**PLEASE PRINT**

**PATIENT INFORMATION**

Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Legal Name\_\_\_\_\_  
(Last) (First) (Middle) (Preferred Name)

Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_ Age\_\_\_\_ Sex M F Marital Status: S M D W

Phone Home (\_\_\_\_)\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_ SSN\_\_\_\_-\_\_\_\_-\_\_\_\_

Address\_\_\_\_ City\_\_\_\_ ST\_\_\_\_ Zip\_\_\_\_

Employer\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_  
(if self employed name and type of business)

Name of school if student\_\_\_\_ Full time  Part time

Referred by\_\_\_\_  
**Circle One:** Doctor Hospital Relative Friend Attorney Coach Advertisement Other

**IN CASE OF AN EMERGENCY, I GIVE PERMISSION TO NOTIFY:**

Name\_\_\_\_ Relationship\_\_\_\_

Home phone(\_\_\_\_)\_\_\_\_ Other phone (\_\_\_\_)\_\_\_\_

**Insurance Information: Please give information about the holder of insurance**

**Primary:**

Insurance Company\_\_\_\_  
Insured Name\_\_\_\_  
Relationship to patient\_\_\_\_  
SSN\_\_\_\_ DOB\_\_\_\_  
Policy or ID No.\_\_\_\_  
Group No.\_\_\_\_  
Employer\_\_\_\_

**Secondary:**

Insurance Company\_\_\_\_  
Insured Name\_\_\_\_  
Relationship to patient\_\_\_\_  
SSN\_\_\_\_ DOB\_\_\_\_  
Policy or ID No.\_\_\_\_  
Group No.\_\_\_\_  
Employer\_\_\_\_

**If you have a Medicare replacement plan (i.e. Secure Horizons, Generations, etc.) please check here YES**

**Please give insurance cards and photo ID to the receptionist for copying.**

**Authorization: My signature indicates that I have read the above and grant authorization of treatment and am responsible for payment of fees and acknowledge that I have been provided access to the SOS HIPPA Privacy Notice and a copy thereof has been made available to me. I also authorize the release of medical information requested by my insurance carrier and authorize payment of medical benefits to the physician and Southwest Orthopaedic & Reconstructive Specialists.**

X\_\_\_\_\_  
Signature of patient, parent, or legal guardian/ Relationship required

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_

Where/what are your current problems? \_\_\_\_\_

Were you injured?  Yes  No Explain \_\_\_\_\_  
Work related accident?  Yes  No Explain \_\_\_\_\_  
Auto Accident?  Yes  No Explain \_\_\_\_\_  
Are you represented by an attorney?  Yes  No Explain \_\_\_\_\_

Date your symptoms/problems began? \_\_\_\_\_ Current severity on a scale of 1-10? \_\_\_\_\_

Were you treated at another hospital or by another physician?  YES  NO  
If Yes by whom and when? \_\_\_\_\_

Have you had X-RAYS MRI CT ULTRASOUND OR OTHER for this problem? (circle which)  
If yes When and Where? \_\_\_\_\_

Did you have surgery for this problem?  YES  NO  
Date and Type \_\_\_\_\_

**MEDICATIONS AND DOSAGES (INCLUDE OVER- THE -COUNTER MEDICINES AND INHALERS)**

Medication	Dosage	Frequently	Medication	Dosage	Frequently
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ALLERGIES	REACTION	ALLERGIES	REACTION
Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Adhesive tape <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Latex <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
IVP Dye <input type="checkbox"/> Yes <input type="checkbox"/> No	_____		_____
Others:	_____		_____

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_  
Activities: \_\_\_\_\_  
Smoke  YES  NO If yes, \_\_\_\_\_ pack(s) daily for \_\_\_\_\_ year(s). Quit smoking in \_\_\_\_\_  
Drink  YES  NO If yes, \_\_\_\_\_ beer, alcoholic drinks, glasses of wine per day month or year? (Circle one)  
Have you ever been addicted to or dependent on drugs or pain medication?  YES  NO  
Are you on a special diet?  YES  NO If yes, type: \_\_\_\_\_  
Height \_\_\_\_\_ Weight: \_\_\_\_\_ If female, are you pregnant?  YES

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_

**ANESTHESIA HISTORY:**

Date of last anesthetic: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever had an adverse reaction/ problem with anesthesia?  YES  NO

If yes, explain: \_\_\_\_\_

Have you had blood relatives with anesthesia problem?  YES  NO

If yes, explain: \_\_\_\_\_

**SURGERIES/DATES:**

Appendectomy	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Cardiac bypass	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Cataracts	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Gallbladder	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Hernia	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Tonsillectomy	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Hysterectomy (female only)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Fracture repair of _____	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Hip replacement <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Knee cartilage <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Knee ligament <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Knee replacement <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Shoulder <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Date _____
Other _____					Date _____
Other _____					Date _____
Other _____					Date _____

**DO YOU HAVE:**

**GENERAL**

Cancer of _____	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Diabetes-insulin dependent	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Diabetes-diet or medication controlled	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Thyroid disease	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Fever	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Night sweats	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Rapid weight loss or gain	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Fatigue	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Anxiety/panic attacks	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Depression	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Jaundice	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Hepatitis	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Swollen ankles	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	High blood pressure	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

**EYES/EARS/HEAD:**

Glaucoma	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Cataracts	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Blindness	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Contacts	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Partial plate	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Dentures	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Hearing loss	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Hearing aids	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Migraine headaches	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Other _____	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

**HEART:**

Heart attack	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Chest pain/angina	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Heart failure	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Heart murmur	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Palpitations	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Rheumatic fever	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Pacemaker	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Other _____	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_

**Lungs:**

Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Recurrent bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	COPD	<input type="checkbox"/> YES <input type="checkbox"/> NO
TB	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

**BREAST:**

Lump	<input type="checkbox"/> YES <input type="checkbox"/> NO	Biopsy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fibrocystic disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mastectomy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		

**ABDOMEN:**

Heartburn	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hiatal hernia	<input type="checkbox"/> YES <input type="checkbox"/> NO
GERD	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent nausea/vomiting	<input type="checkbox"/> YES <input type="checkbox"/> NO
Inguinal hernia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver cirrhosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Peptic ulcer disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

**URINARY TRACT:**

Recurrent bladder/kidney infections	<input type="checkbox"/> YES <input type="checkbox"/> NO	Recent infection	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bladder control problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Prostate disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney stones	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney failure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney transplant	<input type="checkbox"/> YES <input type="checkbox"/> NO

**BONE/JOINTS:**

Rheumatoid arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoarthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Osteoporosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gout	<input type="checkbox"/> YES <input type="checkbox"/> NO
Back Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Joint pains	<input type="checkbox"/> YES <input type="checkbox"/> NO
Muscle Cramps	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fractures	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		

**NEUROLOGICAL:**

Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO	Paralysis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Numbness or tingling	<input type="checkbox"/> YES <input type="checkbox"/> NO	Weakness of arms or legs	<input type="checkbox"/> YES <input type="checkbox"/> NO
Palpitations	<input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart attack	<input type="checkbox"/> YES <input type="checkbox"/> NO	Black out spells	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart failure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Head injury	<input type="checkbox"/> YES <input type="checkbox"/> NO
Palpitations	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

**BLOOD/VESSELS;**

Easy bruising	<input type="checkbox"/> YES <input type="checkbox"/> NO	Excessive bleeding	<input type="checkbox"/> YES <input type="checkbox"/> NO
Taking blood thinners	<input type="checkbox"/> YES <input type="checkbox"/> NO	Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood clots	<input type="checkbox"/> YES <input type="checkbox"/> NO	Phlebitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
PVD	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle cell trait or disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood transfusions	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

**FAMILY HISTORY (INDICATE FAMILY MEMBER IF YES):**

Bleeding tendency _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart disease _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood clots _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	High blood pressure _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoarthritis _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Depression _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatoid arthritis _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart attack _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

