

# ANDREWS

ORTHOPAEDIC & SPORTS MEDICINE CENTER

**To: Andrews Orthopaedic**

**From: \_\_\_\_\_**

**Fax: \_\_\_\_\_**

**Phone: \_\_\_\_\_**

**Physician: \_\_\_\_\_**

**Appointment: \_\_\_\_\_**

Thank you for choosing Andrews Orthopaedic & Sports Medicine Center. To expedite the check-in process for our new patients, we ask that you take the time to fill out our new patient forms beforehand and either fax them to us at (850) 916-3710 for Gulf Breeze or (850) 208-6489 for our 9 Mile Rd. location or bring them with you to your appointment.

Things to bring to your appointment:

- New Patient Forms
- Insurance Card
- Recent X-rays and MRI's (if not taken at a Baptist facility)
- Change of clothes (shorts for knees and sleeveless tops for shoulders)

Our locations are: 1040 Gulf Breeze Pkwy  
Gulf Breeze, FL 32561

Turn into the entrance for Gulf Breeze Hospital. Take your first left and follow the signs for the Andrews Institute. Upon entering the Andrews Institute, proceed to the right of the waterfall towards the elevators. Take the elevator to the second floor. Please refer to the suite listing as you exit the elevator for your doctor's suite.

Baptist Medical Park at Nine Mile  
9400 University Parkway, Suite 407  
Pensacola, FL 32514

Baptist Medical Park at Nine Mile is located on the corner of Hwy 90 and University Parkway just East of Target. Take the elevator to the 4<sup>th</sup> floor and exit to the left. We are in Suite 407.

Feel free to call us at **(850) 916-3700** if you have any questions. We look forward to seeing you!



<b>MAJOR ILLNESS</b>	YES	NO	<b>MAJOR ILLNESS</b>	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrhythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type _____			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis – TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			OTHER: _____		

Please list any **operations/surgeries** you have had:

<b>SURGERY/ REASON</b>	YEAR	<b>SURGERY/REASON</b>	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any **Medications** that you are currently taking:

<b>MEDICATION</b>	DOSE	DOCTOR	<b>MEDICATION</b>	DOSE	DOCTOR
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Do you have any **allergies** to medications/substances?      Yes                  No

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**Family Medical History:** Please list major illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

**Social History:**

Alcohol use:        Yes                No     Drinks per week: \_\_\_\_\_  
 Cigarette use:     Yes                No     Packs per day: \_\_\_\_\_    Years: \_\_\_\_\_  
 Smokeless Tobacco use:    Yes                No                Years: \_\_\_\_\_  
 Illicit Drug use:     Yes                No     Type: \_\_\_\_\_

**Review of Symptoms:** Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

*Agreement of Accuracy:* The information provided in this history form is true and complete to the best of my knowledge.

*Notice of Privacy Practices:* I am aware that Andrews Orthopaedic and Sports Medicine Center has a "Notice of Privacy Practices" in accordance with Baptist Health Care's privacy policies. I understand that a copy is available to me and I agree with these privacy policies.

x \_\_\_\_\_ Date: \_\_\_\_\_

How were you referred to our practice? (circle)

Friend/Relative: \_\_\_\_\_ Physician    Newspaper    Radio    Healthsource

Other: \_\_\_\_\_

