Once Forms are complete, please send to forms@citrusortho.net or send via a portal message or fax to 352-746-6997 for expedited service or bring to appt.

**Please update the below information:**

**Patient full name _____ Date: _____**
Patient address _____
_____

**Please update your current primary insurance:**

Name of Insurance Company_____
ID#_____

**Please list all prescriptions you are currently taking: Please include all over the counter drugs and vitamins:**
Name : Dosage: Frequency:
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Are you currently taking any over the counter blood thinners (i.e. Aspirin)** ◯ Yes ◯ No

**Allergy**:_____**Reaction:** _____ **Allergy**:_____**Reaction:** _____

**Allergy**:_____**Reaction:** _____ **Allergy**:_____**Reaction:** _____

**Please update your preferred pharmacy:**
Pharmacy:_____ Phone:_____

**Height:** _____ **Weight**: _____

**Health screening questions:**

Have you had a flu shot this season? ◯ Y ◯ N If yes, Date/Month_____
Have you ever had an immunization for pneumonia? ◯ Y ◯ N If yes, Date/Month _____
Current cigarette smoker? ◯ Y ◯ N if yes: _____ packs/day
Former cigarette smoker? ◯ Y ◯ N if yes: _____ number of years

Have you fallen in the last year? ◯ Yes ◯ No (if yes, answer one of the two following questions)
I have fallen ONCE in the last year? ◯ Yes ◯ No
I have fallen MORE than once in the last year? ◯ Yes ◯ No
How long ago was your most recent mammogram? _____YEARS _____MONTHS ☐ NA
How long ago was your most recent pap smear? _____YEARS _____MONTHS ☐ NA
How long ago was your most recent colonoscopy? _____YEARS _____MONTHS ☐ NA
Name of primary/family doctor? _____ Last seen? _____ or NA ☐
Do you have a pain management doctor? If yes, who? _____

Signature _____
Dr. Review _____