New Patient Form

Name: ______________________

Date:

Age:

Date of Birth:

Male Female

Who referred you to our office? Name/Address/Phone Number/Specialty:

____

____

Primary Care Physician contact information (if different than referring doctor):

____

Is there anyone else you would like to receive information about your orthopaedic care?____

____

Why are you being seen today? Right Side Left Side Both Sides (*circle one*)

Please describe your current orthopaedic problem/injury (how it started, symptoms, etc): ____

____

____

Problem onset: Sudden Gradual

Date of onset (or approximate duration of problem if onset was gradual): _____________

Circle the number that best represents your average pain level over the last week:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)
Circle the number that best represents your overall disability/dysfunction level:
(No dysfunction) 0 1 2 3 4 5 6 7 8 9 10 (wheelchair/bedbound)

Circle all that apply

Pain Quality: sharp aching stabbing stinging dull throbbing burning tingling

Associated Symptoms: swelling locking/catching instability/giving way stiffness deformity open sores

Timing of Pain: constant morning night worse as day goes on activity-related with walking/standing with running/exercise gets better with activity, or as day goes on

Name: ______________________

start-up pain (worse with first few steps after sitting/resting) variable/irregular

Have you ever had a similar pain/problem in the past? Yes No

What makes it better? ____

What makes it worse? ____

Prior treatment: Rest Cane/Crutches/Walker Orthotics/Shoe Inserts/Pads

Night splint Brace (#wks, type?)____________________ Boot (#wks):__________

Cast (#wks):______ Physical Therapy (#wks):______ Other:

____

Medication (name/dose/duration):____

Injections (How many? % improvement, duration?) ______________________________

Prior Surgery for this problem or body part (who/where/when/what): _________________

____

____

Circle all that apply

Past Medical History: High Blood Pressure Heart Failure Heart Attack/MI

Atrial Fibrillation High Cholesterol Diabetes Thyroid disorder Asthma

Chronic Bronchitis Emphysema/COPD Pneumonia Tuberculosis Sleep Apnea

Blood Clots Pulmonary Embolism Liver Disorder Hepatitis (type):______

GERD/Reflux Stomach Ulcer Ulcerative Colitis/Crohns Kidney Stones

Kidney Failure/Dialysis Polio Neuropathy Charcot-Marie-Tooth Seizure Disorder

Stroke/TIA Cataracts Glaucoma Gout Psoriasis Lupus/SLE Osteoarthritis

Rheumatoid Arthritis Lyme disease HIV/AIDS Osteoporosis Depression Anxiety

Fibromyalgia cancer (specify): ______________________________________

other (specify):____

Are you/could you be pregnant: Yes No

Past Surgical History [list ALL surgeries (example: appendix, tonsils, etc)]

____

____

____

Anesthesia Problems? (describe):____

Circle all that apply

Name: ______________________

Family History: Diabetes Heart Disease Blood Clots/Pulmonary Embolism

Major Anesthesia Problems Charcot-Marie-Tooth Cancer (type?):________________

Other:____

Social History: **Occupation:**____

Student Homemaker Retired Unemployed On Disability

With whom do you live: Mother Father Spouse Partner Children Siblings Alone

Exercise: Never Rarely/Monthly Weekly Daily

What type of exercise? ____

Hobbies: ____

Do you smoke (cigarettes, cigars, e-cigarettes, vaping)? Yes No Quit (when?) _________

What is the most you have ever smoked on a regular basis? _________________________

How many years have you/did you smoke in your life? _____________________________

Do you drink alcohol? Yes No Quit (when?)___________

How much do you drink per week, and drink of choice?

____

Recreational drugs? Current use: Yes No Past use: Yes No

What type? ____

Circle all that apply

Review of Systems: **Hematologic:** Anemia Bleeding Tendency Easy Bruising

Constitutional: Fevers Chills Night Sweats Unplanned Weight Gain? Loss?

Cardiovascular: Chest pain Palpitations Heart Murmur Swollen Legs Leg Cramps

Pulmonary: Chronic Cough Wheezing Shortness of Breath

GI: Nausea/Vomiting Constipation Chronic Diarrhea Blood in Stool

GU: Incontinence Problems Urinating **Endocrine:** Intolerance of: Heat? Cold?

Eyes: Double Vision Blindness **Head/Neck/Ears:** Deafness Sinus Problems

Neurologic: Frequent Headaches Dizziness Balance Problems Numbness/Tingling Weakness **Skin:** Acne Rash **Immunologic:** Swollen Glands Hay fever

Musculoskeletal: Stiffness Joint Pain Joint Swelling Neck or Back Problems

GYN: Menstrual Problems Breast Masses **Psychiatric:** Anxiety Depression

Other:____

Name: ______________________

Please write all ALLERGIES and all MEDICATIONS (including non-prescription meds and supplements) on the separate form provided