NEW PATIENT MEDICAL INFORMATION Acct #_____

Patient Name _____ DOB _____ Age _____ Today's Date _____

Referring Physician _____ Primary Care Physician _____

Employer/School _____ Occupation _____

Dominant Hand: ☐ Right ☐ Left Height _____Weight _____

Date of Injury _____ ☐ On-The-Job Injury ☐ Auto Accident ☐ Sports Injury ☐ Other_____

Is there (or will there be) an attorney involved with this problem? Yes ☐ No ☐

Reason for Visit (Describe problem/injury/symptoms) (Right or Left side?) _____

_____

List *ALL* Allergies (medication and/or non-medication): _____

_____

_____

Previous Treatment for this Problem

(If none, skip to next section)

Physicians/Providers Seen: _____

- ☐ Arthrogram Date: _____Facility_____
- ☐ Bone Scan Date: _____Facility_____
- ☐ Casting/Splinting Date: _____Facility_____
- ☐ Chiropractic/Acupuncture Date: _____Facility_____
- ☐ EMG/Nerve Study Date: _____Facility_____
- ☐ Injection Date: _____Facility_____
- ☐ MRI Date: _____Facility_____
- ☐ Physical Therapy Date: _____Facility_____
- ☐ Vascular Studies Date: _____Facility_____
- ☐ X-Rays Date: _____Facility_____
- ☐ Other Date: _____Explain_____

Relieving Factors:

Makes the problem/pain better?

- ☐ Acetaminophen/Tylenol
- ☐ Anti-Inflammatory/Ibuprofen
- ☐ Aspirin
- ☐ Physical Therapy
- ☐ Crutches
- ☐ Elastic Wrap Compression
- ☐ Heat
- ☐ Ice
- ☐ Muscle Relaxants
- ☐ Prescription Pain Medication
- ☐ Rest
- ☐ Sling
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Aggravating Factors:

Makes the problem/pain worse?

- ☐ Bending
- ☐ Deep Breath
- ☐ Direct Pressure
- ☐ Exercise
- ☐ Grasping
- ☐ Lifting
- ☐ Movement of Area
- ☐ Walking
- ☐ Weight Bearing
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Type of Pain

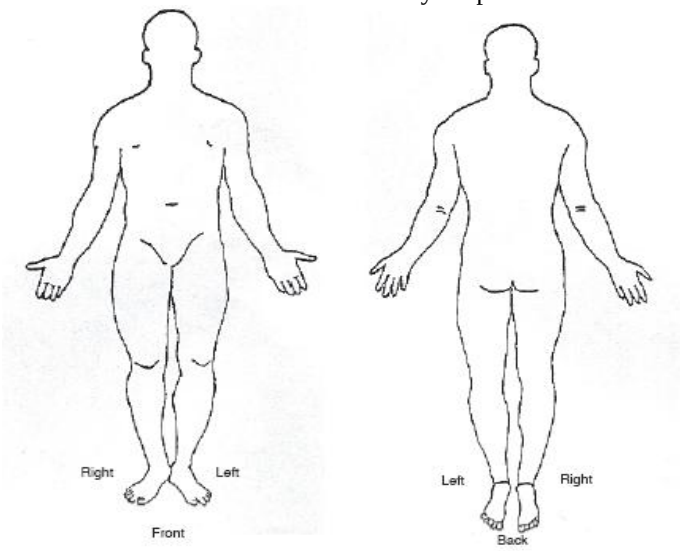
☐ Aching ☐ Numbness ☐ Pins & Needles
☐ Burning ☐ Stabbing ☐ Severe

Describe the severity of the pain: ***0=None / 10=Worst***

0 1 2 3 4 5 6 7 8 9 10

Where are your symptoms now?

Mark the location of your pain on the picture below.
Place an **X** over the area of your pain.
Use an arrow → to show which direction your pain radiates.



Women Only:

Is there a possibility you may be pregnant? ☐ Yes ☐ No
Are you postmenopausal? ☐ Yes ☐ No
Do you take estrogen? ☐ Yes ☐ No
Have you had bone density testing? ☐ Yes ☐ No
When? _____ Where? _____
Have you had a complete hysterectomy?
☐ Yes (Age at time of procedure: _____) ☐ No

Patient Signature: _____
Date: _____
Physician Signature: _____
Date: _____
Anesthesiologist Signature: _____
Date: _____

Medical History/ROS

Check & explain if you have had problems with:

General
Yes ☐ No ☐ Recent Weight Loss/Gain
Yes ☐ No ☐ Fever, Chills, Night Sweats
Yes ☐ No ☐ High Cholesterol
Yes ☐ No ☐ Headaches

Musculoskeletal
Yes ☐ No ☐ Osteoarthritis
Yes ☐ No ☐ Rheumatoid Arthritis
Yes ☐ No ☐ Gout
Yes ☐ No ☐ Joint Pain/Swelling
Yes ☐ No ☐ Hip or Spinal Fractures

Cardiovascular
Yes ☐ No ☐ Heart Disease/Heart Attack/Chest Pain
Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Rapid or irregular pulse?
Yes ☐ No ☐ Do you have a pacemaker?

Neurological
Yes ☐ No ☐ Paralysis/Numbness
Yes ☐ No ☐ Strokes (TIA)

Blood Disorder
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Bleeding
Yes ☐ No ☐ Blood Clots/Phlebitis

Respiratory
Yes ☐ No ☐ Asthma or Breathing Problems
Yes ☐ No ☐ Pneumonia
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Shortness of Breath

Endocrine
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ Liver Disease
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Thyroid Disease
Yes ☐ No ☐ Kidney Disease

Gastrointestinal
Yes ☐ No ☐ Hiatal Hernia/Esophageal reflux
Yes ☐ No ☐ Ulcers
Yes ☐ No ☐ Change in Bowel Function
Yes ☐ No ☐ Blood in Stool

Urinary Tract
Yes ☐ No ☐ Change in bladder function

Eyes/Ears/Nose/Throat
Yes ☐ No ☐ Ear or hearing problems
Yes ☐ No ☐ Glasses or contacts
Yes ☐ No ☐ Sore Throat
Yes ☐ No ☐ Nasal dryness or Congestion

Psychological
Yes ☐ No ☐ Anxiety
Yes ☐ No ☐ Depression

Skin
Yes ☐ No ☐ Rash/legions

Other
Yes ☐ No ☐ Anesthesia Complications
Yes ☐ No ☐ Cancer_____
Yes ☐ No ☐ Surgical Complications_____
Yes ☐ No ☐ Other_____

Family History

Check family members who have been diagnosed with any of the following:

Relationship:

☐ Asthma/Breathing Problems _____
☐ Anesthesia/Surgical Complications _____
☐ Bleeding _____
☐ Blood Clots/Phlebitis _____
☐ Cancer _____
☐ COPD Chronic Obstructive Pulmonary Disease _____
☐ Diabetes _____
☐ Gout _____
☐ Heart Disease/Heart Attack/Chest Pain _____
☐ Hepatitis/Liver Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Osteoarthritis _____
☐ Rheumatoid Arthritis _____
☐ Strokes/Transient Ischemic Attacks (TIA) _____
☐ Thyroid Disease _____
☐ Other/Explain _____

Past Surgical History

Check if you have had any of the following surgeries. (Indicate side by using R = Right /L = Left)

☐ Ankle Side: _____ Type:_____ Date _____
☐ Arm Side:_____ Type: _____ Date _____
☐ Foot Side: _____ Type: _____ Date _____
☐ Hand Side: _____ Type: _____ Date _____
☐ Hip Side: _____ Type: _____ Date _____
☐ Knee Side: _____ Type: _____ Date _____
☐ Leg Side: _____ Type: _____ Date _____
☐ Shoulder Side: ____ Type: _____ Date _____
☐ Wrist Side: _____ Type: _____ Date _____
☐ Spine Surgery Type: _____ Date _____
☐ Abdominal Surgery _____
☐ Cardiac Surgery _____
☐ Neurologic Surgery _____
☐ Pacemaker Implantation Surgery
Type:_____ Date _____
☐ Thoracic Surgery _____
☐ Other/Explain_____
☐ Other/Explain_____

Social History

☐ Single ☐ Married ☐ Divorced ☐ Widowed
Age(s) of child(ren): _____ _____
Exercise/Sports: ☐ Cycling ☐ Gym Activities
☐ Running ☐ Swimming ☐ Team Sports ☐ Walking
☐ Other _____; _____ times per week
Do you use any of the following Tobacco products:
☐ None☐ Cigarettes ☐ Cigars ☐ Smokeless Tobacco
☐ Tobacco Use for ____years Packs per day _____
☐ Quit Tobacco (when) ___
Do you drink alcohol? ☐ Yes ☐ No
☐ Less than 12 drinks per year
☐ Light (1-13 drinks per month)
☐ Moderate (14-30 drinks per month)
☐ Heavy (more than two drinks per day)
Do you have a history of recreational drug use?
☐ Yes Type/Name of Drug _____ ☐ No
Do you take Calcium supplements? ☐ Yes ☐ No
Did either of your parents have osteoporosis?
☐ Yes ☐ No ☐ Unknown
Have you lost an inch or more in height?
☐ Yes ☐ No ☐ Unknown
Have you ever had/taken?
☐ Chemotherapy ☐ Steroids
☐ Fractured Bone (as an adult) ☐ Thyroid Medications
☐ Immunosuppressive Medications