

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: _____
Date: _____ Facility: _____
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 Muscle Relaxants
Anti-Inflammatory/Ibuprofen Prescription Pain Medication
Aspirin
Physical Therapy Rest
Crutches Sling
Elastic Wrap Compression Other
Heat Other
Ice Other

Aggravating Factors:

Makes the problem/pain worse?

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

Type of Pain

- Aching Numbness Pins & Needles
Burning Stabbing Severe

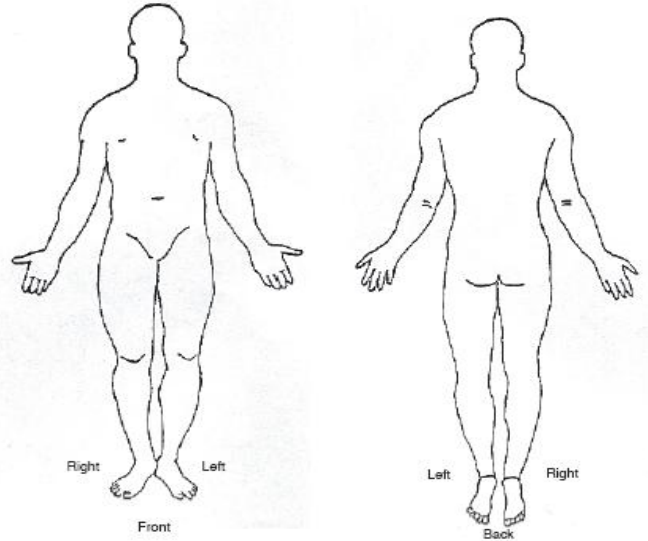
Describe the severity of the pain: 0=None / 10=Worst

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:

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

Past Surgical History

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

- | | | | |
|---|---------------------|-------------|------------|
| <input type="checkbox"/> Ankle | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Arm | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Foot | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Hand | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Hip | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Knee | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Leg | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Shoulder | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Wrist | Side: _____ | Type: _____ | Date _____ |
| <input type="checkbox"/> Spine | Surgery Type: _____ | | Date _____ |
| <input type="checkbox"/> Abdominal Surgery | _____ | | |
| <input type="checkbox"/> Cardiac Surgery | _____ | | |
| <input type="checkbox"/> Neurologic Surgery | _____ | | |
| <input type="checkbox"/> Pacemaker Implantation Surgery | Type: _____ | Date _____ | |
| <input type="checkbox"/> Thoracic Surgery | _____ | | |
| <input type="checkbox"/> Other/Explain | _____ | | |
| <input type="checkbox"/> 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