

New Patient Data Form

Today's Date: _____

Patient Name: _____ **DOB:** _____

Primary Care Doctor: _____ Who referred you for this appointment? _____

Age: _____ Occupation: _____ Is this a Worker's Comp Injury? YES/NO

Reason for this appointment: _____

Have you had x-rays taken? YES/NO Where/When _____ Did you bring x-rays with you? YES/NO

PAIN SCALE: *Circle appropriate number*

0	1 2 3 4	5 6	7 8 9	10
None	Mild	Moderate	Severe	Worst

When did your orthopedic problem start? _____ Are you right handed/left handed? (*circle one*)

Brief history of your orthopedic problem: _____

Sports/Leisure Activities: _____

Medical Problems: (*circle all that apply*)

Heart attack.....Heart Disease.....Atrial Fibrillation.....Thyroid Condition.....Diabetes.....Stroke.....Anemia
 High Blood Pressure.....Emphysema.....Stomach Ulcers.....Kidney Problems.....Liver Problems.....Aneurysm
 Blood Clots.....Cancer: Type _____.

Previous Surgeries	Medications You Take Every Day or Week	Allergies to Medications
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you: Single.....Married.....Separated.....Divorced.....Widow.....Widower Who do you live with? _____

Do you have children? YES/NO How many? _____ Ages? _____

Do you smoke? YES/NO How many packs per day? _____ For how many years? _____

Do you drink alcohol? YES/NO How many drinks per day or per week? _____

Medical history of your parents and/or siblings:

Heart disease.....High blood pressure.....Stroke.....Arthritis.....Cancer: Type _____.....Adopted

System Review (*circle all that apply*)

General: Fever.....Chills.....Runny nose.....Weight loss.....Weight gain
 Central Nervous System: Headache.....Stroke.....Memory loss.....Seizures.....Fainting.....Dizziness.....Numbness
 Hearing: Hearing loss.....Ringing in the ears.....Hearing aide
 Vision: Glasses.....Contact lenses.....Cataracts.....Glaucoma.....Double vision.....Retina problems
 Heart: Chest pain.....Palpitations.....Heart attack
 Lungs: Shortness of breath.....Cough.....Asthma.....Pneumonia
 Digestive: Heartburn.....Reflux.....Nausea.....Vomiting.....Gastritis.....Diarrhea.....Constipation.....Colitis
 Liver: Hepatitis.....Cirrhosis.....Gallstones
 Urinary System: Trouble urinating.....Burning.....Frequency.....Infections.....Incontinence.....Kidney Stones
 Circulation: Bleeding problems.....Leg ulcers.....Peripheral vascular disease.....Phlebitis
 Musculoskeletal: Gout.....Fibromyalgia.....Osteoporosis.....Rheumatoid arthritis
 Skin: Rashes.....Skin cancer.....Psoriasis.....Infections
 Allergies: Iodine.....Latex.....Shellfish.....Metal intolerance
 Mental Health: Depression.....Anxiety.....Mood swings.....Panic attacks
 What is your height? _____ What is your weight? _____