

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? \_\_\_\_\_

Is there a lawsuit pending with this problem? YES/NO