UT Health San Antonio Medicine

New Patient Form

Orthopaedics

Who is your primary care physician? _____Who referred you?_____

Reason for visit?_____ Side: Right / Left

If your injury is the result of an accident please answer the following? Date of injury __/__/__

OR

Where did it happen?
How did it happen
Is this a Worker Compensation Claim **YES /NO** Was this a Motor Vehicle Accident **YES /NO**

If this is not an injury? How long has this bothered you? _____

Have you taken ANY medications for this problem? (Prescription or **OTC**) _____

Have you had any other treatment for th is problem? (Doctor physical therapist, etc.)_____

Have you had x rays or testing done related to this problem? NO / Yes - What test/Doctor?_____

Please rate your discomfort by circling: None = 0 1 2 3 4 5 6 7 8 9 10 = Severe

Quality of the pain (please circle): sharp dull throbbing burning other_____

What makes you condition/Injure better? _____

What makes you condition/Injure worse? _____

MEDICATIONS

Use all current medications: Include dosages & reason: List additional on back of form

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES to Medication? _____

MEDICAL HISTORY Have you ever had: (circle)

Excessive bleeding	Edema/ Leg swelling	Blood clot/DVT	Rheumatoid arthritis	Ulcer
Heart stent	Claudication/Calf pain S	Diabetes	Osteoarthritis	Drug addiction
Heart attack	sleep.apnea	Kidney Disease	Gout	Alcohol addiction
Irregular heartbeat	Asthma	Thyroid Disease	Fibromyalgia Muscle	Reaction to anesthesia
Stroke	COPD	Hepatitis	disease	Blood thinners/Aspirin

Cancer: (Type) _____

Please list other medical conditions, past and present:

_____

_____

CONTINUE ON BACKSIDE

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SURGICAL HISTORY

Please list surgeries you have had:

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

List additional on back of form

REVIEW OF SYSTEMS

In the past month have you experienced any of the following: (circle)

Fever	Chills	Night Sweats	Fatigue	Weight loss
Vision changes	sinus drainage	Headaches	Sore throat	Hearing loss
Cough	Wheezing	Sleep apnea	Short of breath	Sputum
Palpitations	Chest pain	Dizziness	Light headed	Swelling in legs
Heartburn	Nausea/vomiting	Constipation	Diarrhea	Easy bleeding bruising
Tender lymph nodes	Muscle aches	Joint aches	Back pain	Weakness
Insomnia	Depression	Anxiety	Vertigo	Numbness/tingling
Excessive thirst	Skin changes	Freq urination	Hair changes	Heat intolerance

If any family members have any of the conditions listed below "X" under their name also indicate if they are Alive	**Mother**	**Father**	**MGmother**	**MGfather**	**PGmother**	**PGfather**	**Brother/ Sister**	**Brother/ Sister**	**Son/ Daughter**	**Son/ Daughter**
A = alive D = deceased										
Cancer										
Diabetes										
Heart Disease										
Hypertension										
Asthma										
High Cholesterol										
Pheumatoid. Arthritis/Lupus										
Stroke										
Thyroid Disease										
Seizures										

SOCIAL HISTORY

Martial Status Married Divorced Widowed Number of children?_____:

Occupation _____ Employer _____

Tobacco use: **No/Yes** _____packs per day _____ years _____ date quit

Alcohol use: **No/Yes** ____drinks per week Marijuana use: **No/Yes** _____ per week

Fitness/Sports/Athletic activites_____

Patient Signature _____ Date ____/____/____

Provider Signature _____ Date ____/____/____

CONTINUE ON BACKSIDE