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 this 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
New Patient Form

Orthopaedics

**SURGICAL HISTORY**

Please list surgeries you have had:

____________________________   Date ________________
____________________________   Date ________________
____________________________   Date ________________
____________________________   Date ________________

**REVIEW OF SYSTEMS**

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

- Fever
- Chills
- Night Sweats
- Fatigue
- Vision changes
- Sinus drainage
- Headaches
- Sore throat
- Cough
- Wheezing
- Sleep apnea
- Short of breath
- Palpitations
- Chest pain
- Dizziness
- Light headed
- Heartburn
- Nausea/vomiting
- Constipation
- Diarrhea
- Easy bleeding bruising
- Tender lymph nodes
- Muscle aches
- Joint aches
- Back pain
- Insomnia
- Depression
- Anxiety
- Vertigo
- Excessive thirst
- Skin changes
- Frequent urination
- Hair changes
- Heartburn
- Nausea/vomiting
- Constipation
- Back pain
- Palpitations
- Chest pain
- Dizziness
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- Diarrhea
- Easy bleeding bruising
- Tender lymph nodes
- Muscle aches
- Joint aches
- Back pain
- Insomnia
- Depression
- Anxiety
- Vertigo
- Excessive thirst
- Skin changes
- Frequent 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

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<th>Condition</th>
<th>Mother</th>
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<th>MGmother</th>
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<th>PGmother</th>
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<th>Brother/Sister</th>
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**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 activities________________________________________________

Patient Signature ___________________________________________ Date ____/____/____

Provider Signature _________________________________________ Date ____/____/____

CONTINUE ON BACKSIDE