****

**NEW PATIENT FORM**

**Date:\_\_\_\_\_-\_\_\_\_\_- \_\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_-\_\_\_-\_\_\_ Age\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_**

**Referred by a physician?**\_\_\_Yes\_\_\_No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary care physician** if different from above. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. REASON FOR VISIT(LOCATION):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Describe Pain (sharp , dull , ache)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.**  **WHEN** did your problem begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Constant, or Come and Go?** \_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** **HOW** did your problem begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.** What are the symptoms (pain, locking, clicking , numbness)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.**  What makes the problem **Worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Better**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6.** Have you had any diagnostic tests for this problem? (Please **check** all that apply)

□ X-rays □ Arthrogram (Dye injection) □ Electromyogram (EMG)

□ MRI or CT □ Injections (Cortisone) □ Nerve Conduction Study (NCS)

Dates:\_\_\_\_\_\_\_\_\_Place:\_\_\_\_\_\_\_\_\_\_\_ Have they been delivered here? ⁭Yes ⁭No Do you have them? ⁭Yes ⁭No

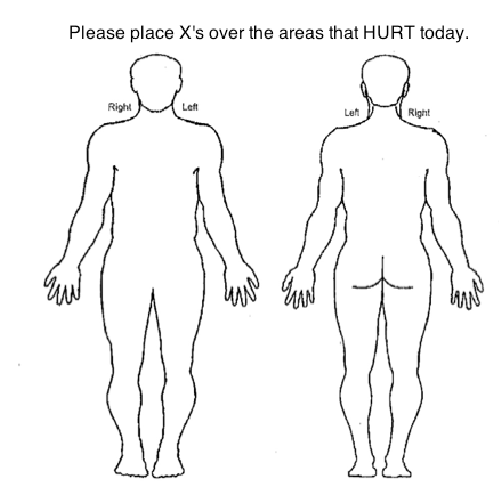
**9.** Were you seen in the **Emergency Room for this problem**? ⁭Yes **Date**\_\_\_\_\_\_ No ⁭

**10**. Have you seen an **Orthopedist** for this problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11.** What treatment have you had for this problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12.** **PAIN SCALE ( least) 1 2 3 4 5 6 7 8 9 10 (greatest**)

**13.** Are you **RIGHT** ⁯ or **LEFT ⁯ Handed**

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For office use only:

F/S? -

**14. PAST MEDICAL HISTORY:**

⁭ Diabetes ⁭ Stomach Ulcers/Reflux

⁭ Asthma/Emphysema/COPD ⁭ Stroke

⁭ High Blood Pressure ⁭ Kidney disease/failure(specify)

⁭ Heart Problems:

⁭ Easy Bleeding or Bruising Contagious conditions: ⁭ HIV ⁭ Hepatitis ⁭ TB/Other (specify)

⁭ Cancer (*What type!)* **Other:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15 .ALLERGIES:** **Do you have allergies to: *Specify Allergy and Reaction (i.e. itching, rash, hives, difficulty breathing*)**

Drugs ⁭ Yes ⁭ No What : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tape? ⁭ Yes ⁭ No What : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex? ⁭ Yes ⁭ No What : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food? ⁭ Yes ⁭ No What : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lidocaine or Steroids ⁭ Yes ⁭ No What : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16.** **MEDICATIONS: Do you take any medications?**  Please list ***all*** medications ***and*** their doses.

**17. FAMILY HISTORY:** Does *anyone* in your family have a history of *any* medical problems? (Please **check** all that apply)

⁭ Arthritis ⁭Blood Clots ⁭ Problems with Anesthesia

⁭ Cancer ⁭ Osteoporosis ⁭ Heart Disease

⁭ Diabetes \_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**18. SOCIAL HISTORY:**

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Time ⁯ Retired ⁭ Disabled ⁭

Do you smoke? ⁭Yes ⁭ No How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did you smoke? ⁭Yes ⁭ No Quit when?\_\_\_\_\_\_\_\_\_

Do you drink alcohol? ⁭ Yes ⁭ No ⁭ Rarely ⁭ Socially ⁭ Daily How many drinks per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any addiction to drugs or medications? ⁭ Yes ⁭ No Which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you ⁭ Married ⁭ Single ⁭ Committed ⁭ Widowed ⁭ Divorced/Separated Do you live alone? ⁭Yes ⁭ No

Do you exercise? ⁭ Daily ⁭ Weekly ⁭ Monthly ⁭ Rarely ⁭ Never

**19. REVIEW OF SYSTEMS :**

DO YOU HAVE PROBLEMS WITH THE FOLLOWING:

**General** ⁭ fevers/chills ⁭ sweats ⁭ tiredness/fatigue ⁭ weight loss ⁭ None

**Eyes** ⁭ blurring ⁭ double vision ⁭ vision loss ⁭eye pain ⁭ photophobia ⁭ None

**ENT**  ⁭ ear pain/discharge ⁭ hearing problems/ringing ⁭ nosebleeds ⁭hoarseness ⁭difficulty swallowing ⁭ None

**CV** ⁭ chest pain ⁭ irregular heart beat ⁭ passing out ⁭ orthopnea ⁭ swelling in legs ⁭ None

**Resp** ⁭shortness of breath ⁭wheezing ⁭cough ⁭ cough up blood ⁭ None

**GI** ⁭nausea/vomiting ⁭ diarrhea ⁭ constipation ⁭ abdominal pain ⁭blood in stool ⁭ black bowel movements ⁭ None

**GU** ⁭burning ⁭ loss of urine ⁭ difficulty voiding ⁭ infections ⁭ blood in urine ⁭ sexual dysfunction ⁭ None

**MSK** – See HPI

**Skin**  ⁭rash ⁭itching ⁭dryness ⁭strange lesions ⁭ None

**Neurologic** ⁭ weakness ⁭seizures ⁭ dizziness ⁭balance problems ⁭memory problems ⁭ None

**Psychiatric** ⁭depression ⁭anxiety ⁭sleep disturbance ⁭hallucinations ⁭suicidal thoughts ⁭ None

**Endocrine** ⁭cold or heat intolerance ⁭thirsty all the time ⁭peeing a lot ⁭large weight gain/loss ⁭ None

**Heme/Lymph** ⁭easy bruising ⁭anemia ⁭enlarged glands ⁭bleeding ⁭ None

**Allrgc/ Immun** ⁭Itching ⁭frequent colds/infections ⁭HIV exposure ⁭ None