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NEW PATIENT INITIAL EVALUATION

Patient Name: Date:

Primary Phone number: Email Address:

Family/Primary Doctor: Primary Doctor's Phone:

Family/Primary Doctor's Address:

Who referred you to this practice? (name & address please):

INSTRUCTIONS: Please complete the following questions before you see the doctor. ***Select the word or phrase that best describes your situation. You may select more than one answer per question***. Answer the question in as much detail as possible. Write additional information in the blank lines. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care.

THANK YOU.

Age: Sex: Male Marital Status: Married Height: Weight:

Dominant Hand: Right Occupation:

What are you seeing the doctor for?

Duration of symptoms:

When did the problem first start, or when did the injury occur?

Is this injury work related? Select

Have you seen a doctor in past for this problem or injury? Select

Explain in your own words how this injury occurred:

What treatment have you had?

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Select all of the items listed below to which you are allergic:

- ☐ No known allergies
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Morphine
- ☐ Codeine
- ☐ Iodine/Betadine
- ☐ Radiographic Dyes
- ☐ Adhesive Tape
- ☐ Other (Specify):

Select all of the medical problems listed below that you have now:

- ☐ I have no known medical problems
- ☐ Hypertension
- ☐ Coronary artery disease
- ☐ Peripheral vascular disease
- ☐ Adult onset diabetes
- ☐ Childhood onset diabetes
- ☐ Past heart attack
- ☐ Asthma
- ☐ Ulcers
- ☐ Hepatitis A/ B / C Type
- ☐ Cancer Type
- ☐ Tuberculosis
- ☐ Liver disease
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Emphysema
- ☐ COPD/ Lung disorder
- ☐ Immune disorder
- ☐ Overweight
- ☐ Osteomyelitis
- ☐ Blood Clot (DVT)
- ☐ Other (Specify):

How much alcohol do you consume? Select

Do you now, or have you ever smoked cigarettes? Select | If yes, how many packs a day and for how many years?

Do you now, or have you ever used the following drugs?

- ☐ Recreational
- ☐ Cocaine
- ☐ Marijuana
- ☐ Other (Specify):

Has anyone in your immediate family ever had any of the following? Select the illnesses that apply.

- ☐ None known
- ☐ Cancer
- ☐ Leukemia
- ☐ Stroke
- ☐ Hypertension
- ☐ Coronary artery disease
- ☐ Rheumatic fever
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Colitis
- ☐ Bleeding tendency
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Seizure disorder
- ☐ Alcoholism
- ☐ Other (Specify):

Have you ever had a blood clot? Select

If so, when? | What treatment did you have?

Any previous broken bones: Select

If so, which bones and when?

Have you ever had a blood transfusion: Select | If so, when? Did you have any problems with the transfusion?

Select all surgeries listed below you may have had. Please indicate the year of surgery:

- ☐ No previous surgeries
- ☐ Appendectomy
- ☐ Cataract extraction
- ☐ By-pass / open heart
- ☐ Gall bladder
- ☐ Hernia repair
- ☐ Other (Specify): _____

- ☐ Hysterectomy
- ☐ Lumbar laminectomy
- ☐ Mastectomy
- ☐ Tonsillectomy
- ☐ Prostate surgery
- ☐ Hip/Knee surgery — Specify Type and Date

What medications are you currently taking? Please include both prescription and non-prescription medications.

Medication	Dose	# Times Per Day	Medication	Dose	# Times Per Day

Please select any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

☐ Advil ☐ Arthrotec ☐ Daypro ☐ Ibuprofen ☐ Lodine ☐ Naprelan ☐ Naproxen

☐ Oruvail ☐ Tylenol ☐ Ultram ☐ Other: _____

Please select any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

☐ Nausea ☐ Diarrhea ☐ Gastric Ulcers ☐ Upset stomach ☐ Vomiting

☐ Other: _____

Please select any medication that you may be taking on a regular basis?

☐ Aspirin ☐ Axid ☐ Coumadin ☐ Cytotec ☐ Heparin ☐ Maalox ☐ Mylanta

☐ Pepcid ☐ Prevacid ☐ Prilosec ☐ Tagamet ☐ Zantac

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Select YES or NO.

SYMPTOMS		COMMENTS
Chest Pain	No	If yes, please describe.
Dizziness	Select	If yes, please describe.
Dry cough	Select	If yes, please describe.
Productive cough	Select	If yes, please describe.
Difficulty breathing	Select	If yes, please describe.
Irregular heartbeat	Select	If yes, please describe.
Swelling in the legs	Select	If yes, please describe.
Lack of appetite	Select	If yes, please describe.
Nausea	Select	If yes, please describe.
Vomiting	Select	If yes, please describe.
Diarrhea	Select	If yes, please describe.
Constipation	Select	If yes, please describe.
Abdominal cramping	Select	If yes, please describe.
Varicose veins	Select	If yes, please describe.
Bruising	Select	If yes, please describe.
Bleeding	Select	If yes, please describe.
Nose bleeds	Select	If yes, please describe.
Joint pain / stiffness	Select	If yes, please describe.
Muscle pain or cramps	Select	If yes, please describe.
Difficulty seeing	Select	If yes, please describe.
Difficulty hearing	Select	If yes, please describe.
Difficulty swallowing	Select	If yes, please describe.
Difficulty sleeping	Select	If yes, please describe.

☐ **I acknowledge that everything I have answered is true and correct to the best of my knowledge and understand that this will become a part of my permanent medical record.**

Patient Signature

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
THIS FORM WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD.