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# NEW PATIENT INITIAL EVALUATION

Patient Name: _____ Date: _____

Family/Primary Doctor: _____ 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***. Check 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 Female Height: _____ Weight: _____

Marital Status: Single Married Widowed Handed: Right Handed Left Handed

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? Yes No

Have you seen a doctor in past for this problem or injury? Yes No If yes, who and when?

_____

Explain in your own words how this injury occurred:

_____

_____

_____

What treatment have you had?

_____

_____

**TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:**

Check mark anything listed below to which you are allergic:

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

Check mark any 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
- Cancer
- 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?

- I'm a non-drinker
- I'm a recovering alcoholic
- I drink only occasionally
- I drink weekends only
- An average of 1-2 drinks per day
- An average of 2-3 drinks per day
- An average of 3-4 drinks per day
- More than 6 drinks per day

Do you now, or have you ever smoked cigarettes?

- Yes, I am currently a smoker. I smoke _____ packs a day
- I have smoked for _____ years
- No, but I used to smoke I smoked for _____ years
- No, I have never smoked

Do you now, or have you ever used drugs?

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

Has anyone in your immediate family ever had any of the following? Circle 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? Yes No

Check mark any surgeries listed below you may have had. 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 _____

Any previous broken bones: _____

Blood transfusion: Yes No Year: _____

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

| Medication | Dose | # Times Per Day | Medication | Dose | # Times Per Day |
|---|---|---|---|---|---|
| | | | | | |
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Please check mark 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 check mark 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 check mark the medication below if you are currently taking any of them 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? Check mark YES or NO.

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

**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.**