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NEW PATIENT HISTORY FORM

Date: ___/___/___

Age: ___ Ht: ___ Wt: ___ Occupation _____ Hobbies _____

Are: you ? Right Handed ? Left Handed?

CHIEF ORTHOPAEDIC COMPLAINT: Explain why you are here,include body part & symptoms.

DATE OF ONSET OR INJURY _____ -

Did this occur at work? Yes No

Past Treatment for this injury? _____

(physical therapy,medications including otc,braces,surgeries,etc.)

CURRENT MEDICATIONS: List all medications you are now taking,including prescription and over the counter medications

_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: Please list medications/drugs you are allergic to and your reaction.

_____	_____
_____	_____
_____	_____

Do you smoke? Yes No Cigarettes Cigar Pipe Chew tobacco/dip

Amount per day? # Of years Have you quit? Yes No How long?

Do you drink alcohol? Yes No How often?

Recreational drugs? Yes No Type/Frequency

PAST MEDICAL HISTORY: What illnesses or conditions have you had or currently have

Diabetes _____	Heart Trouble _____
Asthma _____	High Blood Pressure _____
Kidney _____	Lung _____
Liver _____	Cancer _____
Blood Disorders _____	Psychiatric Trouble _____

PREVIOUS SURGERIES:

PREVIOUS HOSPITALIZATIONS: (NOT SURGERIES)

FAMILY HISTORY: (e.g. cancer,diabetes,heart disease)

REVIEW OF SYSTEMS

Please circle any health problems in the following areas:

HEART

- Coronary Artery Disease
- Hypertension
- High Cholesterol
- Heart Murmur
- Heart Failure
- Heart Attack
- Other

RESPIRATORY

- Asthma
- Emphysema
- Sleep Apnea
- Shortness of Breath
- Other

NEURO

- Numbness
- Seizure Disorder
- Tremors/Stroke
- Other

MUSCULOSKELETAL

- Osteoarthritis
- Osteoporosis
- Chronic Muscle Pain
- Swollen Joints
- RA
- Fibromyalgia
- Other

ENDOCRINE

- Thyroid Disease
- Diabetes
- Excessive weight gain
- Excessive weight loss
- Other

URINARY

- Burning
- Blood in urine
- Frequency
- Other

VASCULAR

- Phlebitis
- Clotting/Bleeding
- Easy Bruising
- Anemia
- Other

HEENT

- Blurry Vision
- Hearing Loss
- Painful Swallowing
- Other

SKIN

- Rash Lesions
- Psoriasis
- Moles
- Other

GASTROINTESTINAL

- Reflux
- Peptic Ulcer
- Hepatitis
- Gallstones
- Other

PSYCHIATRIC

- Anxiety
- Depression
- ADHD
- Schizophrenia
- Other

GENERAL

- Cancer
- Fever Chills
- Night Sweats
- TB
- Other

GENITALS/BREASTS

- Tumor Erectile Dysfunction
- Large Prostate Menopause Breast Cancer

Is there any chance that you may be pregnant? Yes No NA

PATIENT SIGNATURE _____

DATE: _____