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

HOW DID INJURY OCCUR?____

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

WHAT PHARMACY DO YOU USE?________________________________

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: ____________________