NEW PATIENT / PROBLEM SHEET

Appointment Date: _____ Chart #: _____ Provider: _____

BP _____ / _____ Pulse _____
Temp. _____ Hgt. _____ / _____ Wgt.

Patient Name (Please Print) _____

Age _____ F ☐ M ☐ Dominant hand: R ☐ L ☐ Height _____ / _____ Wgt. _____ Did you bring x-rays? Y ☐ N ☐

Who requested that you visit this office? (Name) _____ ☐ MD ☐ PA ☐ Attorney ☐ None (Self-Referral)

What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other _____

What body part is involved? Please mark in table below. If you have more than one, see receptionist.

Neck ☐	and radiates to	☐ R arm ☐ L arm ☐ Neither	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
Back ☐	and radiates to	☐ R leg ☐ L leg ☐ Neither	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger T2345 ☐ R ☐ L	Hip ☐ R ☐ L	Ankle ☐ R ☐ L	Toe ☐ R ☐ L

How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years. Have you had a problem like this before? Y ☐ N ☐

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ No injury (Onset was: ☐ Gradual or ☐ Sudden) ANSWER: COMMENTS
Why do you think it started?

☐ INJURY (☐ Accident ☐ Sport NOT Auto or work)
Date _____. Where and How did it happen?
What Sport _____ School _____

☐ INJURY AT WORK Date _____.
From a ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach?

☐ WORK RELATED – (BUT NO INJURY)
Date _____. How did your job cause this problem?

☐ AUTO ACCIDENT Date _____ How was your car hit?

On a scale of 0-10 (10 is the worst) how severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning _____

The pain is: ☐ Constant ☐ Comes and goes (intermittent). Does your pain wake you from sleep? ☐ Yes ☐ No

Do you have ☐ Swelling ☐ Bruise ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowel or bladder

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in Bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing

What makes your symptoms better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _____

Which medications have you been taking now (or previously) for this problem? _____

Have you had any of these treatments? Injection ☐ Y ☐ N Brace ☐ Y ☐ N Physical Therapy ☐ Y ☐ N Cane/Crutch ☐ Y ☐ N

Were you seen in the E.R. for this problem? ☐ Y ☐ N Which E.R.? _____ Date _____

Are you here today as a result of the E.R. visit? ☐ Y ☐ N Who saw you in the E.R. (name)? _____ ☐ MD ☐ PA

What tests/scans have you had for this problem? ☐ X-Rays ☐ MRI ☐ CAT scan ☐ Bone scan ☐ Nerve Test (EMG/NCV)

Have you already had surgery for a problem in this same area either recently or in the past? ☐ Y ☐ N Please list below.

Procedure #1 _____ Surgeon _____ City _____ Date _____

Procedure #2 _____ Surgeon _____ City _____ Date _____

Current work status? ☐ Regular ☐ Light Duty (How long? _____) ☐ Not working due to this problem ☐ Disabled ☐ Retired ☐ Student

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: Disability ☐ Y ☐ N Workman's Comp ☐ Y ☐ N Unemployment ☐ Y ☐ N

CHART # _____

MEDICAL HISTORY FORM

Patient Name _____ **Family Doctor:** _____ **Pt. DOB:** _____

N4 5
E5
(1)

Past Medical History:

☐ Anemia	☐ Diabetes	☐ HIV / AIDS	☐ Rheumatoid Arthritis
☐ Asthma	☐ Drug or Alcohol Abuse	☐ Kidney Disease	☐ Seizures
☐ Bleeding Disorder	☐ Emphysema	☐ Liver Disease / Hepatitis	☐ Sickle Cell Trait / Disease
☐ Blood Clots	☐ Gout	☐ Menopause	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Mental Health Disorders	☐ Thyroid Trouble
☐ Depression	☐ High Blood Pressure	☐ Osteoporosis	☐ Ulcers
	☐ High Cholesterol	☐ Parathyroid Trouble	☐ Other _____

Surgical History Procedure(s) and Date(s):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications (including dosage and frequency):

N3E4
(1)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Drug Allergies and Reaction:

_____ _____
_____ _____
_____ _____

Reaction to anesthesia: Yes ☐ No ☐
(if yes, describe reaction)

_____

FH
N4.5
E5
(1)

Family History: Have any of your blood relatives had:

☐ Osteoarthritis	☐ Cancer
☐ Rheumatoid Arthritis	☐ Diabetes
☐ Respiratory Disease	☐ Heart Disease
☐ High Blood Pressure	☐ Blood Diseases
☐ Bleeding Disorder	☐ Gout
☐ Osteoporosis	☐ Other
☐ Nerve Disorders	_____
☐ Muscle Disorders	

SH
n4.5
E5
(1)

Social History

Marital History: M S D W

Occupation: _____

Employer: _____

Alcohol: ☐ Never ☐ Rarely ☐ Weekly ☐ Daily

Tobacco: ☐ Current ☐ Former Smoker ☐ Nonsmoker

Packs per day: _____ Number of years: _____ Year Quit: _____

N2E3
(M/S)

Review of Systems

M/S Have you had **prior problems** with the same orthopedic condition in the past? ☐ Yes ☐ No

Explain _____

Do **other joints** have ☐ Morning Stiffness ☐ Joint Pain ☐ Joint Swelling ☐ None

(Check all that apply to you or mark None

N3E4
(2+)

CON. . . . ☐ None ☐ Fever Recurs ☐ Recent Weight Loss
HEAD . . ☐ None ☐ Headache
EYE . . . . ☐ None ☐ Worsening Vision ☐ Seeing Double Images ☐ Blurry Vision
ENT . . . . ☐ None ☐ Loss of Hearing ☐ Hoarseness

N4,5
E5
(10)

CV . . . . . ☐ None ☐ Chest Pain or Discomfort ☐ Palpitations
RS . . . . . ☐ None ☐ Difficulty Breathing ☐ Chronic Cough
GI . . . . . ☐ None ☐ Decrease in Appetite ☐ Difficulty Swallowing ☐ Heartburn ☐ Nausea
☐ Vomiting ☐ Abdominal Pain w/Anti-inflammatories ☐ Blood in Stool
GU . . . . . ☐ None ☐ Pain during urination ☐ Urinary Frequency Increased ☐ Blood in Urine
END . . . . ☐ None ☐ Excessive Thirst ☐ Temperature Intolerance
SK . . . . . ☐ None ☐ Dry Skin ☐ Skin Lesions ☐ Skin Rash
HEM . . . ☐ None ☐ Easy Bleeding ☐ Easy Bruising
NEU . . . . ☐ None ☐ Dizziness ☐ Convulsions
PSY . . . . ☐ None ☐ Sleep Disturbances ☐ Drug/Alcohol Addiction ☐ Depression

For Office Use Only: New patient Form – Reviewed for completeness by _____ **Date** _____

Nursing Dept Updates:

Date _____ Initials _____ Changes: ☐ None ☐ Noted on form / Date _____ Initials _____ Changes: ☐ None ☐ Noted on form
Date _____ Initials _____ Changes: ☐ None ☐ Noted on form / Date _____ Initials _____ Changes: ☐ None ☐ Noted on form
Date _____ Initials _____ Changes: ☐ None ☐ Noted on form / Date _____ Initials _____ Changes: ☐ None ☐ Noted on form
Date _____ Initials _____ Changes: ☐ None ☐ Noted on form / Date _____ Initials _____ Changes: ☐ None ☐ Noted on form
Date _____ Initials _____ Changes: ☐ None ☐ Noted on form / Date _____ Initials _____ Changes: ☐ None ☐ Noted on form

Reviewed by MD_____ Date: _____ Reviewed by MD_____ Date: _____ Reviewed by MD_____ Date: _____
Reviewed by MD_____ Date: _____ Reviewed by MD_____ Date: _____ Reviewed by MD_____ Date: _____
Reviewed by MD_____ Date: _____ Reviewed by MD_____ Date: _____ Reviewed by MD_____ Date: _____