



NEW PATIENT INFORMATION

Please answer all questions on both pages

Circle answers where indicated

Name: _____ Age: _____ Today's Date: _____

This space for office use only

Have you been referred here by another doctor? Yes / No If yes, who? _____
If not, how did you hear about us? I'm a previous patient / family / friend / insurance company / internet
yellow pages / Bone and Joint clinic web site / athletic trainer / other (please list) _____

Employer: _____ Occupation: _____
Is this injury / problem work related? Yes / No
Is there a lawsuit or lawyer involved? Yes / No

What sports do you play? _____ What School? _____

WHAT problem brings you to the office today / What hurts? _____

WHEN were you injured / What date did this problem begin? _____

HOW did the injury / problem occur? (gradual onset, fall, accident, etc.) _____

DESCRIBE your pain (circle all that apply): Sharp / Stabbing / Dull / Aching / Numb / Tingling
Burning / Pins + Needles / Popping / Locking / Instability / Swelling / Constant / Intermittent
Other: _____

What makes your pain **WORSE**: Walking / Standing / Car rides / Sports / Twisting / Lifting / Bending
Overhead activity / Reaching back / Pivoting / Bed time / Stair climbing / Getting up out of a chair
Other: _____

What helps **RELIEVE** your pain? Rest / Ice / Elevation / Heat / Medicine / Nothing / other: _____

RATE your pain on a scale of 1 to 10 (10 being the worst):

At it's worst: _____ At it's best: _____ Typical day: _____

Has this problem been **EVALUATED** before coming to this office? Yes / No If yes, by whom?

What **TREATMENT** have you had for this problem? None / Tylenol / Advil / Ice / Physical Therapy
Injections / Surgery Other: _____

Did it help? Yes / No / Stayed the same / Made it worse

Prior to today, have you had any **IMAGING STUDIES** for this current problem? X-rays / MRI / CT scan
Bone scan / Other: _____

Circle one; Is the pain: getting better / getting worse / staying the same.

Have you ever injured this body part in the **past**? Yes / No explain: _____

Has anyone in your **family** ever had: High blood pressure / Diabetes / Heart disease / Cancer / Tuberculosis / Lung disease / Bleeding problems / Anesthesia problems

Do you / did you ever use tobacco? Yes / No If yes, what type? _____

How many packs per day? _____ How many years? _____ When did you / do you plan to quit? _____

Do you drink alcohol? Yes/ No What type? _____ How much? _____

Have you ever taken drugs other than those prescribed by a doctor? Yes / No Please list these: _____

Please list all previous **surgeries**: _____

Have you ever had any of the following? Please circle all that apply.

Heart Attack	Fibromyalgia	Anesthesia problems	Cancer:
Congestive Heart Failure	Arthritis	Anemia	Type _____
Atrial fibrillation	Rheumatoid Arthritis	Blood clotting disorders	HIV
Aortic Aneurysm	Lupus	Bleeding problems	AIDS
COPD	Obesity	Asthma	Amputation:
Chronic Bronchitis (smoker's cough)	Seizures	Lung Disease	Toe / foot / knee
Gastric Ulcer	Strokes	Tuberculosis	Diabetes:
Kidney dialysis	Mental Illness	Hepatitis:	Controlled / Not Controlled
Transplant:	Bone infection	Type _____	Diabetic complicatons:
Lung / Heart / Liver	Unexplained weight loss	Throat/ear problems	Skin ulcer / neuropathy
Major Depression	Eye problems	High Blood Pressure	Kidney / eye

Please list any other **medical / health problems**: _____

What **medications** do you take on a regular basis? _____

Are you **allergic** to any medications, latex, shellfish or Betadine? Yes / No Please list: _____

Patient Signature: _____