

**NEW PATIENT INFORMATION FORM**

Today's date \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you: Right-handed? \_\_\_\_\_ Left-handed? \_\_\_\_\_

**ORTHOPEDIC PROBLEM:** Briefly describe why you are here: \_\_\_\_\_  
\_\_\_\_\_

Specific injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, date of injury \_\_\_\_\_

If no, how long has it been bothering you? \_\_\_\_\_

Does anything make it feel worse? \_\_\_\_\_

Does anything make it feel better? \_\_\_\_\_

Have you had any treatment for this? \_\_\_\_\_

Have you been seen elsewhere for this problem? \_\_\_\_\_

By whom? \_\_\_\_\_

X-rays taken? Yes \_\_\_\_\_ No \_\_\_\_\_

MRIs taken? Yes \_\_\_\_\_ No \_\_\_\_\_

**Occupation** Job title: \_\_\_\_\_

Full duty \_\_\_\_\_ Limited duty \_\_\_\_\_

Have you missed work due to this problem? Yes \_\_\_\_\_ No \_\_\_\_\_

Student: \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_

**Medical / Legal**

Is this a Workers Compensation injury?

Yes \_\_\_\_\_ No \_\_\_\_\_

Are there any liability/legal proceedings pending or in progress regarding this problem?

Yes \_\_\_\_\_ No \_\_\_\_\_

**MEDICATIONS**

Please list any **medications you are now taking**, including aspirin, over-the-counter medicines, supplements, or pain medicines prescribed for this problem:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History**

Are you allergic to: \_\_\_\_\_ Penicillin \_\_\_\_\_ Sulfa drugs  
\_\_\_\_\_ Xylocaine/Novocaine

Please name any other medications you are allergic to: \_\_\_\_\_

List any illnesses or injuries you have now or had in the past. Include any problems that you are taking medicine for or that you see your doctor for.

\_\_\_\_\_  
\_\_\_\_\_

For women who are in or have gone through menopause: Have you had a bone density study?

If yes, when? \_\_\_\_\_ Results? \_\_\_\_\_

List any surgeries you have had and date of surgery:

\_\_\_\_\_  
\_\_\_\_\_

**Review of Systems**

- Do you have heart/lung problems? yes no
- Do you have diabetes? yes no
- Do you have a history of ulcer? yes no
- Do you have psoriasis? yes no
- Do you have bleeding problems? yes no
- Do other joints bother you? yes no

**Has anyone in your immediate or extended family ever had: Indicate who in your family has had illness.**

- \_\_\_\_\_ Problems with anesthesia during surgery
- \_\_\_\_\_ Bleeding problems
- \_\_\_\_\_ Heart Attack
- \_\_\_\_\_ Diabetes mellitus (sugar diabetes)
- \_\_\_\_\_ Tuberculosis
- \_\_\_\_\_ Rheumatoid arthritis
- \_\_\_\_\_ Osteoarthritis
- \_\_\_\_\_ Gout
- \_\_\_\_\_ Osteoporosis
- \_\_\_\_\_ Other \_\_\_\_\_

Do you smoke cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ Sometimes \_\_\_\_\_ Never \_\_\_\_\_ Daily

**Interests:**

Activities/Hobbies \_\_\_\_\_  
Sports \_\_\_\_\_

Family Physician: \_\_\_\_\_

Who sent you for this consultation? \_\_\_\_\_

Have you been a patient in our office before?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been a prior patient in any orthopedic office?

Yes \_\_\_\_\_ No \_\_\_\_\_

When: \_\_\_\_\_

Where: \_\_\_\_\_

**PATIENT SIGNATURE:**

\_\_\_\_\_

**PARENT / LEGAL GUARDIAN:**

\_\_\_\_\_