NEW PATIENT MEDICAL HISTORY

Patient Name: ____	**Height:** _______	**Weight:** _______
Race: ○ African American ○ Asian ○ Caucasian ○ Native American/Alaskan ○ Pacific Islander ○ Other ○ Unknown ○ Decline to Answer		
Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown ○ Decline to Answer		
Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other: ____________________________		
Preferred Pharmacy: ____		
Referral Source (Doctor Name): _________________________	**Other (ex: Google)**:_____________________	

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness ○ Other: ________________________________

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck ○
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back ○
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back ○
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back ○
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks ○
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone ○
Thumb	○ Right	○ Left	Foot	○ Right	○ Left	
Index	○ Right	○ Left	Great Toe	○ Right	○ Left	
Middle	○ Right	○ Left	2nd Digit	○ Right	○ Left	
Ring	○ Right	○ Left	3rd Digit	○ Right	○ Left	
Little	○ Right	○ Left	4th Digit	○ Right	○ Left	
			5th Digit	○ Right	○ Left	

Pain radiates from/to (ex: low back to right leg) ____

History of Present Illness

1. Is your problem the result of an injury of accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex: 2 months): ______________________________

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) ___________________________

2. Are you represented by an attorney? ○ Yes ○ No

Attorney Name: ____________________________

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe:

____

____

4. **Have you been seen in an ER for this Problem?** ○ Yes ○ No

Treating ER: _________________________________ Date (mm/dd/yyyy): __________________________

5. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep? ○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

History Present Illness (continued)

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching overhead

11. Are there any symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing/Treatment

Have you had any prior tests for this problem?

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Tests (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of Treatment	Status of Symptoms after treatment (select only those that apply)			Date of Treatment
Ice	○ Improved	○ Worsened	○ Unchanged	________________
Heat	○ Improved	○ Worsened	○ Unchanged	________________
Rest	○ Improved	○ Worsened	○ Unchanged	________________
NSAIDs	○ Improved	○ Worsened	○ Unchanged	________________
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	________________
Chiropractor	○ Improved	○ Worsened	○ Unchanged	________________
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	________________
Home Exercise Prog.	○ Improved	○ Worsened	○ Unchanged	________________
Surgery	○ Improved	○ Worsened	○ Unchanged	________________
Injections	○ Improved	○ Worsened	○ Unchanged	________________
Bracing	○ Improved	○ Worsened	○ Unchanged	________________
TENS unit	○ Improved	○ Worsened	○ Unchanged	________________

Other/Comments:____

Previous Hospitalizations/Surgeries: ○ None

		Orthopedic on side:	Right	Left
○ Aneurysm (Brain) Surgery	○ Hysterectomy			
○ Aortic Bypass/Vascular Surgery	○ LAP Band/Gastric Bypass Surgery	Arthroscopy: Knee	○	○
○ Appendectomy	○ Lumpectomy	Arthroscopy: Shoulder	○	○
○ Cataract (Eye) Surgery	○ Mastectomy	Carpal Tunnel Release	○	○
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer	Rotator Cuff Repair	○	○
○ Heart Surgery	○ Stents	Total Hip Replacement	○	○
○ Hernia Repair		Total Knee Replacement	○	○
Other Surgery:___________________________________		Total Shoulder Replacement	○	○
____		Spinal Surgery Level: ______________		

Medical Questions

Mark all that currently apply:

○ Metal in Body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months: ○ None for all

				NONE	Comments:
CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue	○	___________________
EYE	○ Blurred vision	○ Double Vision	○ Vision Loss	○	___________________
ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	___________________
CV	○ Chest Pain	○ Palpitations		○	___________________
RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath	○	___________________
GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	___________________
GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	___________________
SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	___________________
NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	___________________
PSY	○ Change in Bowel	○ Change in Bladder	○ Dizziness	○	___________________
ENDO	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	___________________
HEM	○ Fever	○ Heat/Cold Intolerance	○ Night Sweats	○	___________________
	○ Easy Bleeding	○ Easy Bruising	○ Anemia	○	___________________

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments: ____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments: ____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments: ____			

Social History

Do you smoke? ○ Current, every day smoker ○ Current, some day smoker ○ Former Smoker ○ Never

○ Heavy tobacco smoker ○ Light tobacco smoker

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _______

Please list work restrictions, if any:

____

Occupation: ________________________ **Employer:** ____________________________ ○ **Student**

Allergies

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Latex allergy? ○ Yes ○ No

Medications

Please list all medications you take on a regular basis: ○ None

Medications	Dosage and Frequency (e.g. 20 mg, once/day)
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________

Medical Conditions

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: ___________	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: ______________	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: __________	○ Pacemaker
○ Bone or Joint Infections	○ HIV/AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: ______________	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy/Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _______
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type ______________	Last A1C: ______________	○ Stroke/TIA
		○ Tuberculosis

Please list any other conditions or details of conditions marked above: ________________________________

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Signature:____ **Date:** __________________________