# New Patient/New Condition Form

**Preferred name:** _____ **Primary Care Physician:** _____

**Age:** _____ **Sex:** ☐ Male ☐ Female **Reason for visit:** _____

**I am:** ☐ Right-handed ☐ Left-handed **Who referred you to Bone & Joint?** _____

**Was there a specific injury:** ☐ Yes ☐ No **If yes, date of injury:** ____ / ____ / ____

**Where did injury occur?** ☐ Work ☐ Home ☐ Sports/recreation ☐ Car accident ☐ School ☐ Other _____

**How long have symptoms been present?:** _____ **Location of pain:** ☐ Right ☐ Left ☐ Both ☐ N/A

**Severity of pain (circle one):** 0 1 2 3 4 5 6 7 8 9 10 **Do you have night pain:** ☐ Yes ☐ No

**Quality of Pain:**

- ☐ Stabbing
- ☐ Aching
- ☐ Dull
- ☐ Sharp
- ☐ Pins/needles
- ☐ Throbbing
- ☐ Shooting
- ☐ Burning

**Which bothers you:**

- ☐ Neck
- ☐ Arm
- ☐ Hip
- ☐ Shin
- ☐ Back
- ☐ Elbow
- ☐ Groin
- ☐ Ankle
- ☐ Shoulder
- ☐ Wrist
- ☐ Thigh
- ☐ Foot
- ☐ Other
- ☐ Hand
- ☐ Knee
- ☐ Heel

**Do you have:** ☐ None

- ☐ Giving out
- ☐ Instability
- ☐ Motion loss
- ☐ Visible swelling
- ☐ Catching
- ☐ Clicking
- ☐ Popping
- ☐ Locking

**Pain aggravated by:** ☐ Standing ☐ Walking ☐ Sitting/driving ☐ Running ☐ Up stairs ☐ Down stairs ☐ Working ☐ Other: _____

**Treatments attempted:**

- ☐ None
- ☐ Rest/activity modification
- ☐ Ice
- ☐ Anti-inflammatories
- ☐ Narcotics
- ☐ Wheelchair
- ☐ Boot/Insoles
- ☐ Crutches
- ☐ Physical therapy
- ☐ Injection, **date** _____
- ☐ Surgery

**Previous tests and where were they obtained:** ☐ None

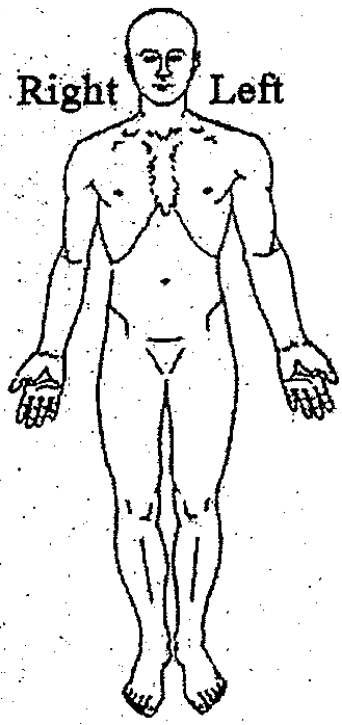
- ☐ X-ray _____
- ☐ MRI _____
- ☐ CT/CAT scan _____

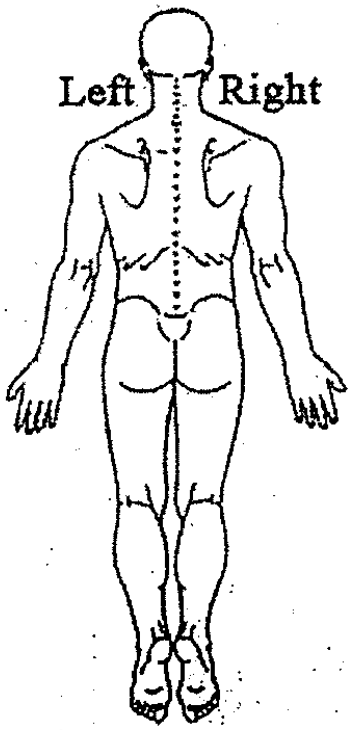
**Did you bring your images with you?:** ☐ Yes ☐ No

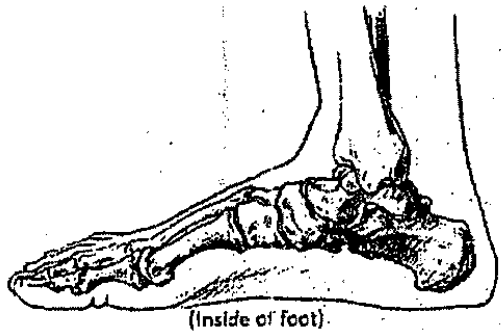
**Is there an ongoing worker's compensation claim associated with complaint?** ☐ Yes ☐ No

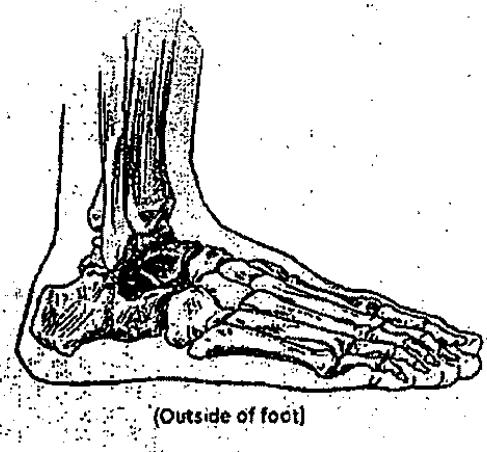
**Do you have a lawyer, or is a lawsuit associated with the complaint?** ☐ Yes ☐ No

**Please draw where your pain is located on the diagrams below:**



## Medical History

**Please list any health problems with which you are currently diagnosed.** ☐ None

**Height:** _____
**Weight:** _____

☐ Lung disease ☐ High blood pressure ☐ Thyroid problems ☐ Seizures
☐ Heart disease ☐ Blood clot (Pulmonary embolism/DVT) ☐ Stomach ulcers ☐ Cancer
☐ Osteoarthritis ☐ Asthma ☐ Depression ☐ Kidney disease ☐ Stroke/TIA
☐ Rheumatoid arthritis ☐ Anemia ☐ Abnormal heart rhythm ☐ Hepatitis/HIV/AIDs ☐ Anxiety
☐ Unintentional weight loss ☐ High cholesterol ☐ Diabetes: If yes, what is most recent A1C?: _____ Date last taken? _____
☐ Liver Disease/jaundice ☐ Gout ☐ Infections: Please explain: _____
☐ Easy bleeding ☐ Other illness: Please explain: _____

**Females Only:** **Date of last menstrual period:** ___/___/___ **Currently pregnant?** ☐ Yes ☐ No ☐ Possibly

## Surgical History

**Please list any previous surgeries and approximate dates of surgery.** ☐ None

| Surgery: | Date: | Surgery: | Date: |
|---|---|---|---|
| 1. | / / | 5. | / / |
| 2. | / / | 6. | / / |
| 3. | / / | | |
| 4. | / / | | |

**Known allergies to anesthesia:** ☐ No ☐ Yes
Describe: _____

## Medications

**Please list any medications that you currently use including over-the-counter medications, vitamins, herbs, and prescribed drugs.** ☐ None

| Medication: | Dose: | | Dose: |
|---|---|---|---|
| 1. | | 7. | |
| 2. | | 8. | |
| 3. | | 9. | |
| 4. | | 10. | |
| 5. | | 11. | |
| 6. | | 12. | |

**Are you on any blood thinners (Aspirin, Anti-inflammatories, Warfarin/Coumadin, Plavix, Xarelto, Lovenox, etc.)?** ☐ Yes ☐ No

**Preferred pharmacy, name and location:** _____ **Phone:** ( ) _____

## Allergies

☐ None known ☐ Narcotics ☐ Ibuprofen/anti-inflammatories ☐ Iodine ☐ Latex
☐ Penicillin ☐ Metals/jewelry ☐ Aspirin ☐ Chlorhexidine ☐ Diagnostic dye
☐ Sulfa-drugs ☐ Adhesive tape ☐ Acetaminophen ☐ Other: _____

Do you have a Family History of Blood Clots? ☐ Yes ☐ No ☐ Unsure

## Social History

**Occupation:** _____ ☐ Retired ☐ Unemployed
**Company:** _____ **Are you disabled?** ☐ No ☐ Yes, Reason _____

**Adults only:**

**Marital status:** ☐ Single ☐ Married ☐ Long term relationship ☐ Divorced ☐ Widowed
**Do you live alone?** ☐ Yes ☐ No **With whom?** _____
**Use tobacco (smoke/vape/dip)?** ☐ Yes ☐ No _____ **Packs/Day** ☐ Quit: _____ **Months ago** _____ **Years ago**
**Do you drink alcohol?** ☐ Yes ☐ No **Number of drinks per week:** _____
**Do you use recreational drugs?** ☐ Yes ☐ No **Please list:** _____

## Miscellaneous Information

**Please list any more information that may be important to your visit today.**

_____

_____

## Signatures

**Name of person completing form:** _____ **Relationship to patient:** ☐ Self ☐ Parent ☐ Guardian

**Signature of patient, parent, or legal guardian:** _____ **Date:** ___/___/___

**Signature of physician:** _____ **Date:** ___/___/___