Orthopaedics and Sports Medicine

New Patient

Date:______________

Time:______________

Patient Name: ____ MRN: ____________________

Date of Birth: __________________ Age: ____________________ Hand Dominance: Right or Left

Family MD: ____________________________ Referring MD: _____________________________

Pharmacy: ____

Reason for visit: ____

Date of Injury: ____

Past Medical History

____Allergies	____Depression	____High Blood Pressure	____Seizures/Epilepsy
____Anxiety	____Diabetes	____High Cholesterol	____Stomach Ulcers
____Arrhythmia	____Headaches	____Infection/MRSA	____Stroke
____Arthritis	____COPD/Emphysema	____Kidney Stones	____Thyroid Disease
____Asthma	____Enlarged Prostate	____Liver Disease	____Urinary Infections
____Rheumatoid Arth	____Heart Attack (MI)	____Osteoporosis	____Degenerative Disc Disease
____Bleeding Problem	____Heart Murmur	____Psoriasis/Eczema	____ Cancer:______________
____Bronchitis	____Heart Failure	____Pregnant?	____Other:_______________
____Blood Clots	____Gout	____Reflux (GERD)	

Medications

1.______________________________ 2.___________________________ 3.______________________________

4.______________________________ 5.___________________________ 6.______________________________

Allergies (Allergic Reactions)

Medication:__________________________ Reaction____

Medication:__________________________ Reaction____

Any:_______________________________ Reaction____

Any:_______________________________ Reaction____

Surgical History

Surgery:____ Date____________________________

Surgery:____ Date____________________________

Surgery:____ Date____________________________

Social History

Single Married Divorced Widowed Number of Children:_________

Occupation:_____________________ Employer:_________________________ Disabled ? ___________________

Tobacco use: Yes _____ per day or No Alcohol use: Yes ____per day or No

Accident / Personal Injury Workers Compensation Case Lawsuit

Please complete second sheet…Thank you!

Review of Systems / Please circle all that apply and are CURRENT issues

Review Of Systems ***Please circle all that apply and are current issues***				
GENERAL	Appetite Changes Fatigue	Weight Change	Fever Night Sweats	Chills
HEENT	Headache Runny Nose Snoring	Vision Changes Allergies Eye Pain	Nose Bleed Difficulty Swallowing	Hearing Changes Sore Throat Hoarseness Dry Eyes
NECK	Swollen Glands	Pain	Stiffness	Goiter
CARDIOVASCULAR	Chest Pain Varicose Veins	Leg/Arm Swelling	Palpitations Heart Disease	Passing Out
RESPIRATORY	Cough	Wheezing	Shortness of Breath	Sputum Coughing up Blood
GI	Nausea/Vomiting Crohns/Ulcer colitits Abdominal Pain	Heartburn Constipation Indigestion	Diarrhea Blood in Stool Tarry Stool	Change in Bowel Function Jaundice
URINARY/GU	Painful Urination Urinary Frequency	Vaginal Discharge Blood in Urine	Sexual Dysfunction On dialysis?______	Incontinence
NEUROLOGIC	Seizures Tremor Parkinsons	Dizziness Weakness RSD	Numbness Paralysis Fibromyalgia	Tingling Headaches Memory Loss
MUSCULOSKELETAL	Joint Pain Muscle Weakness Fingers turn white	Muscle Pain Joint Swelling Raynaud's Disease	Stiffness Instability Osteoarthritis	Back Pain Worsening Deformity
PSYCH	Anxiety Nervousness	Depression Schizophrenia	Stressed	Sleep Trouble
SKIN	Rash Swelling/Tight Skin Hair Changes	Changing Moles Lumps Nail Changes	Itching Masses Skin Cancer	Hives Ulcers Scleroderma
HEME	Anemia/Sickle Cell Hepatitis Type____	Easy Bruising AIDS/HIV	Excessive Bleeding	Blood Clots
ENDO	Increased Thirst	Breast Discharge Lupus	Swollen Glands	Weather Intolerance

Family History

Diabetes, Heart Attack, Seizures, Cancer, Rheumatoid Arthritis, Osteoarthritis, Other:___________________________

PhysicalExam____

____

____

How long has this been bothering you?____

Did you have an injury?_______________________________If yes, date of injury:___________________

Describe your pain (circle): constant, night, rest, medial, lateral, posterior, anterior, deep, achy, stabbing, burning, sharp, catching, grinding, locking, popping, giving way, stiffness, swelling, throbbing, radiating, numbness?

Do certain activities bother you?____

What have you done for the pain? Heat, ice, elevation, crutches, medication? _____________________

Treatments you have had in the past for this problem? Brace, physical therapy, MRI, x-rays, injections, pain clinic, chiropractor, surgery? ____

How bad is your pain on a scale from 1 – 10?

____

Have you seen a Harbin Orthopaedic Physician in the past? _______ If yes, whom? ________________________________

______Dictated **______Not Dictated** **______Needs x-rays Dictated**

HPI:

PE:

Assessment:

Plan:

For Physician / Provider Use…