

New Braunfels Orthopaedics & Sports Medicine

New Patient Medical History

Name: _____ Date: _____ Check one: M F

Age: _____ Height: _____ / _____ Weight: _____ Dominant Hand: R L

Who may we thank for referring you to us? _____

What is the main reason for this visit? Pain Numbness Weakness Other: _____

What body part is involved? *Please mark below:*

<input type="checkbox"/> Neck		Shoulder <input type="checkbox"/> Right <input type="checkbox"/> Left		Arm <input type="checkbox"/> Right <input type="checkbox"/> Left		Hand <input type="checkbox"/> Right <input type="checkbox"/> Left	
Radiates to:		Elbow <input type="checkbox"/> Right <input type="checkbox"/> Left		Wrist <input type="checkbox"/> Right <input type="checkbox"/> Left		Finger <input type="checkbox"/> Right <input type="checkbox"/> Left	
<input type="checkbox"/> R Arm <input type="checkbox"/> L Arm							
<input type="checkbox"/> Back		Pelvis <input type="checkbox"/> Right <input type="checkbox"/> Left		Knee <input type="checkbox"/> Right <input type="checkbox"/> Left		Foot <input type="checkbox"/> Right <input type="checkbox"/> Left	
Radiates to:		Hip <input type="checkbox"/> Right <input type="checkbox"/> Left		Ankle <input type="checkbox"/> Right <input type="checkbox"/> Left		Toe <input type="checkbox"/> Right <input type="checkbox"/> Left	
<input type="checkbox"/> R Leg <input type="checkbox"/> L Leg							

How long has this problem been present? ___ Days ___ Weeks ___ Months ___ Years

Check the **ONE** box below that best describes how your problem started. Then use the space to the right to answer the question below the box you checked. Use as much space as needed.

- No Injury:** Onset: Gradual Sudden
Why do you think it started? _____
- Injury:** (From an accident or sport **NOT** work or Auto)
Date: _____ What sport? _____
School: _____ Describe where & how it happened. _____
- Injury at work:** Date: _____
From: Lifting Twisting Bending Pulling
- Work related, but NO injury:**
Date: _____ How did job cause this problem? _____
- Auto Accident**
Date: _____ Describe accident. _____

Answer: _____

On a scale of 0-10 (10 is needing an ambulance), how severe is your pain? (circle)

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: Sharp Dull Stabbing Throbbing Aching Burning
 The pain is: Constant Intermittent (Comes & Goes) Does the pain wake you up? Y N

Do you have: Swelling Bruising Numbness Weakness Tingling Loss of bladder/bowel

Since your problem started, is it: Better Worse Unchanged

What makes your symptoms **WORSE**? Standing Walking Lifting Exercise
 Twisting Lying down Bending Squatting
 Kneeling Stairs Coughing Sneezing

Which make your symptoms **BETTER**? Rest Elevation Ice Heat Other

What medications are you taking now (or previously) for this problem? _____

Have you had any of the following for this problem?
 Injection Brace Physical Therapy Cane/crutch

Were you seen in the ER for this problem? Y N Which ER and date? _____

What tests/scans have you had for this problem?
 Xrays MRI CAT scan Bone scan
 Nerve test EMO/NCV

Have you had surgery in this same area before? Y N Please list below:

Procedure: _____ Surgeon: _____ City: _____ Date: _____

Procedure: _____ Surgeon: _____ City: _____ Date: _____

Work status: Regular Light Duty (How long?) _____ Disabled Retired Student
 Not working due to this problem **What was the last date you worked your job?** _____

Are you currently receiving or plan to apply for: Disability Unemployment Workers Comp

Please continue on next page.

Name: _____

Date: _____

Review of Systems:

Have you ever had a PRIOR issue with the same condition that you are here for today? Y N

Do you have OTHER JOINTS with: Swelling Morning Stiffness Pain

Please check all that apply to you or mark NONE:

NONE

- | | | | |
|----|--|--|---|
| 1 | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Stomach pain w/ anti-inflammatories | <input type="checkbox"/> |
| 2 | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| 3 | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> |
| 4 | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of appetite |
| 5 | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Vision Loss |
| 6 | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Trouble swallowing |
| 7 | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> |
| 8 | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> |
| 9 | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> |
| 10 | <input type="checkbox"/> Rash | <input type="checkbox"/> Skin ulcers | <input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis |
| 11 | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> |
| 12 | <input type="checkbox"/> Depression | <input type="checkbox"/> Drug/Alcohol addiction | <input type="checkbox"/> Sleep disorder |
| 13 | <input type="checkbox"/> Bleeding easily | <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Anemia |

Past Medical History:

What medications do you take? None Please list w/ dosage: _____

Are you allergic to any medications? No Yes

List: _____

List any other products or foods that you are allergic to: (e.g. eggs, latex, iodine, etc.) _____

Are you a diabetic? No Yes Treatment: Insulin Diet Oral Meds None

Are you taking or have you ever taken blood thinners? No Yes

List: _____

Do you have any of the below medical problems? (Please check below)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart attack (year) _____ | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Brochitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Other: _____ | | | |

Past Surgical History:

What operations have you had and when? None List: _____

Have you ever had a reaction to anesthesia? No Yes

Past hospitalizations OTHER THAN surgery? None List: _____

Have you ever had a reaction to a blood products? No Yes

Family History:

Have any direct relatives had any of the following? If so, which relative? None

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Rheumatoid arthritis _____ | | |

Do any relatives have the same condition you are being seen for today? No Yes

Social History:

Do you use tobacco? N Y Packs/day ____ **Alcohol Use/# ?** N Y ____ Daily ____/Week ____ Other

History of substance abuse? N Y What? _____

Any significant weight loss? N Y Amount: _____

Do you live alone? N Y **Do you exercise?** N Y How often? _____

Please sign: The information on this medical history is accurate and to the best of my knowledge.

Patient: _____

Reviewed by: _____

MD/PA Date: _____