

# NEW PATIENT HISTORY



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Provider Initials: \_\_\_\_\_

Date of Service: \_\_\_\_\_

**Type of problem (check all that apply):**

- pain
- fracture (broken bone)
- sprain / strain
- swelling (new)
- weakness
- open wound
- numbness / tingling
- other \_\_\_\_\_

**Location of your injury / condition:** \_\_\_\_\_

**Social History:**

What is your occupation? \_\_\_\_\_

What is your marital status?  single  married  divorced  separated  widowed

Please describe your cigarette smoking status.

currently (every day)  currently (some days)  in the past  never

Please describe your oral/vaping nicotine status.

currently (every day)  currently (some days)  in the past  never

**I acknowledge that currently I am a smoker, and my provider strongly suggests I quit smoking. I have read this suggestion from my orthopedic provider. Please mark here to indicate:**

**Medical History (check all that apply):**

- anesthesia problems
- arthritis
- MS (multiple sclerosis)
- anemia
- asthma
- birth defect
- bleeding disease
- depression
- blood clots
- bruise easily
- heart disease
- diabetes
- seizure disorder
- hepatitis
- high blood pressure
- high cholesterol
- reflux
- kidney disease
- osteoporosis
- fibromyalgia
- TB (tuberculosis)
- COPD / emphysema
- lupus
- stomach ulcers
- Parkinson's
- heart attack
- rheumatoid arthritis
- thyroid disease
- GERD / heartburn
- HIV
- mitral valve prolapse
- stroke
- polio
- neurological disease
- other connective tissue disorder
- other illness \_\_\_\_\_
- none

Please indicate if you have had any of the following cancers:

- brain
- breast
- colon / rectal
- lung
- liver
- ovarian
- prostate
- skin
- stomach
- other cancer
- none

Please indicate if your PARENTS or GRANDPARENTS have had any of the following:

- anesthesia problems
- bleeding disease
- arthritis
- heart disease
- family history of malignant
- hyperthermia
- none

**Surgeries (check all that apply):**

Please indicate if you have had any of the following surgeries.

I have had NO SURGERIES. If you have had no surgeries, please skip ahead to the next section.

Please indicate if you have a pacemaker, hearing aid, or metal in your body.

pacemaker  hearing aid  metal - location: \_\_\_\_\_  none

- ankle  left  right  both
- appendectomy  yes
- arthroscopic knee  left  right  both
- arthroscopic shoulder  left  right  both
- bunion / hammertoe  left  right  both
- breast biopsy  left  right  both
- breast cancer lump removal  left  right  both
- breast reconstruction  left  right  both
- carotid artery  yes
- carpal tunnel  left  right  both

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**Surgeries: (continued)**

- |   |                               |                                    |                                 |
|---|-------------------------------|------------------------------------|---------------------------------|
| cataract                                  | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| cesarean section                          | <input type="radio"/> 1       | <input type="radio"/> 2            | <input type="radio"/> 3 or more |
| colon removal                             | <input type="radio"/> partial | <input type="radio"/> total        |                                 |
| D&C                                       | <input type="radio"/> single  | <input type="radio"/> multiple     |                                 |
| defibrillator                             | <input type="radio"/> yes     |                                    |                                 |
| foot                                      | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| gallbladder                               | <input type="radio"/> open    | <input type="radio"/> laparoscopic |                                 |
| hand                                      | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| heart bypass                              | <input type="radio"/> yes     |                                    |                                 |
| heart valve replacement                   | <input type="radio"/> yes     |                                    |                                 |
| hemorrhoidectomy                          | <input type="radio"/> yes     |                                    |                                 |
| hernia                                    | <input type="radio"/> yes     |                                    |                                 |
| hip fracture & surgery                    | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| hysterectomy                              | <input type="radio"/> partial | <input type="radio"/> total        |                                 |
| kidney removal                            | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| leg circulation                           | <input type="radio"/> single  | <input type="radio"/> multiple     |                                 |
| lung                                      | <input type="radio"/> left    | <input type="radio"/> right        |                                 |
| mastectomy                                | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| other breast surgery                      | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| ovary removal                             | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| prostate surgery                          | <input type="radio"/> TURP    | <input type="radio"/> removal      |                                 |
| rotator cuff repair                       | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| sinus                                     | <input type="radio"/> yes     |                                    |                                 |
| spinal decompression                      | <input type="radio"/> neck    | <input type="radio"/> lower back   |                                 |
| spinal fusion                             | <input type="radio"/> neck    | <input type="radio"/> lower back   |                                 |
| thyroid                                   | <input type="radio"/> yes     |                                    |                                 |
| tonsillectomy                             | <input type="radio"/> yes     |                                    |                                 |
| total hip replacement                     | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| total knee replacement                    | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| tubal ligation                            | <input type="radio"/> yes     |                                    |                                 |
| ulcer                                     | <input type="radio"/> yes     |                                    |                                 |
| ulnar nerve                               | <input type="radio"/> left    | <input type="radio"/> right        | <input type="radio"/> both      |
| vasectomy                                 | <input type="radio"/> yes     |                                    |                                 |
| <input type="radio"/> other surgery _____ |                               |                                    |                                 |

**Allergies (check all that apply):**

Mark here if you have no known medical allergies.

Are you allergic to any of the following? Please list any reaction(s) you have.

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="radio"/> latex _____      | <input type="radio"/> betadine _____ | <input type="radio"/> metal(s) _____         |
| <input type="radio"/> Penicillin _____ | <input type="radio"/> sulfa _____    | <input type="radio"/> malignant hyperthermia |
|  |                                      | <input type="radio"/> other _____            |

**Medications:**

Mark here if you take no regular medications.

Please list all medications you are currently taking or provide a list of your current medications. Include prescriptions, over-the-counter medications, and vitamins.

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency