New Patient Information Form

Name _____ Date _____ Age ____ Right ____ or Left ____ Handed?

How did you hear about us? _____

Referring Physician _____ **UPIN #** _____

Address _____ City _____ State ____ Zip Code _____

Phone _____ Fax _____ email _____

Primary Care Physician _____ **UPIN #** _____

Address _____ City _____ State ____ Zip Code _____

Phone _____ Fax _____ email _____

Is this a work related problem? Yes No If yes, list your OWCP or L&I Claim# _____

If disabled, when did you last work? _____

Is a lawyer involved with this problem? If so, name/address _____

*** Chief Complaint: Please describe the problem** that brings you into the office today: _____

*** <u>History of Present Illness</u>**

1. Where is the problem located? _____

Right ___ Left ___ Both (please be specific) _____

2. When and How did this problem begin?(date of injury) _____

3. Circle the **symptoms** that best describe your problem:

Stiffness Pain Instability Numbness Swelling Other _____

4. If you have pain, please circle the description(s) that are most appropriate:

Sharp Throbbing Aching Burning Stabbing Heavy Dull

5. Circle the number corresponding to the **intensity** of your pain or other symptoms:

(1 is no pain and 10 is the worst pain imaginable) **1 2 3 4 5 6 7 8 9 10**

6. Is your pain getting better Gradually? Better Rapidly? Getting worse? Worse Gradually? Worse Rapidly?

7. What improves your symptoms? _____

8. What makes your symptom(s) worse? _____

9. Have you had any **previous surgeries** for this problem? Yes No

If yes, please describe: (please include where, when, the surgeon, and if they helped)

_____

_____

10.**What studies** have you had for this problem? (Circle all that apply)

X-rays CT MRI Nerve Study (EMG) Arthrogram Bone Scan

***<u>Review of Symptoms and past Medical History</u>**

1. Do you have any allergies? Yes No if so, please list

To **Medications?** _____

To **Foods?** _____

Are you allergic **to latex**? Yes No Are you allergic to **iodine?** Yes No

2. Please list all the medications you now take including dose and frequency:

_____

_____

3. Please list all surgeries you have had in the past. List any complications (bleeding, infection, blood clots, etc)

_____

_____

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***Review of Symptoms and Past Medical History** Do you have or had any of the following Problems?

(Circle any that apply)	No	Yes	Comments
General (weight gain/loss, fatigue, insomnia)			
Eye (glass/contacts, cataracts, glaucoma)			
Ear/Nose /Throat (sinus trouble, hearing loss, ringing, etc.)			
Heart (irregular heartbeat, high blood pressure chest pain, fluttering in chest, Coronary disease)			
Lung (shortness of breath, lung disease, persistent cough)			
Stomach (decreased appetite, constipation, heartburn, nausea, diarrhea, hepatitis A, B, C)			
Muscles/ Bones (arthritis, fractures, sprains)			
Urinary Tract (kidney stone, bladder or kidney infections, prostate problems)			
Skin (masses, blisters, dermatitis)			
Neurology (problems with swallowing, seizures, tingling, numbness, severe headaches)			
Mental Health (anxiety, depression, other)			
Endocrine (increased thirst, diabetes, thyroid)			
Blood/Lymph (bleeding or clotting problems, anemia, swollen or enlarged lymph nodes)			
Immunological (hay fever, lupus, HIV/AIDS)			

Please list any other medical problems you have been treated for: _____

_____

_____

Which of these problems required hospitalization? _____

Family History: Please Circle if any of your **family members** have had the following:

Diabetes **Hypertension** **Stroke**

Heart attack **Cancer** **Depression**

Arthritis **Rheumatoid** **Gout**

Kidney disorder **Other** _____

Social History:

1. Are you currently working? Yes No What is your occupation? _____
2. Are you married? Yes No Other Relationship: _____ Children? No Yes #___
3. How many individuals live with you now? ___
4. Do you smoke or use tobacco? Yes No How many packs per week? _____
5. Do you consume alcohol? Yes No How many drinks per week? _____
6. Do you currently or have you ever had a problem with drug or alcohol abuse? Yes No

Physician Signature_____ Date_____