NEW PATIENT INFORMATION

Date: ____________________

Name: ____ **Age**: ________ ☐ **Male** ☐ **Female**

Please give a short explanation of your pain and how it affects you:

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Medication Allergies ____

Other Allergies ____

Past Medical History

☐ AIDS	☐ Crohn's Disease	☐ HIV Positive	☐ Rheumatic Fever
☐ Anemia	☐ Defibrillator	☐ Hypertension	☐ Schizophrenia
☐ Arthritis	☐ Depression	☐ Kidney Disease	☐ Shingles
☐ Asthma	☐ Dialysis	☐ Liver Disease	☐ Shortness of Breath
☐ Bipolar Disorder	☐ Diabetes	☐ Migraine Headaches	☐ Stroke
☐ Bleeding Disorders	☐ Eating Disorder	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Bronchitis	☐ Emphysema	☐ Osteoarthritis	☐ Thyroid Disease
☐ Cancer Cervical	☐ Glaucoma	☐ Pacemaker	☐ TIA's (mini stroke)
☐ Cancer Lung	☐ Gout	☐ Parkinson's Disease	☐ Tuberculosis
☐ Cancer Ovarian	☐ Headache	☐ Pneumonia	☐ Ulcerative Colitis
☐ Cancer Prostate	☐ Heart Disease	☐ Polio	☐ Ulcers/Reflux
☐ Chemotherapy	☐ Hepatitis A	☐ Prostate Problem	☐ Valve Replacement
☐ Chicken Pox	☐ Hepatitis B	☐ Psoriasis	☐ Other ______________
☐ Cirrhosis	☐ Hepatitis C	☐ Radiation Therapy	

Past Surgical History

☐ Unremarkable	☐ Carpal Tunnel	☐ Mitral Valve Replacement	☐ Tunneled Dialysis Cath
☐ Abdominal Surgery	☐ Cataract Extraction	☐ Nephrectomy: Native	☐ UPPP
☐ Amputation	☐ Cholycystectomy	☐ Nephrectomy: Transplant	☐ Urinary Incontinence Sx
☐ Anterior Cervical Fusion	☐ Craniotomy	☐ Pacemaker	☐ Vertebroplasty
☐ AV Fistula Creation	☐ Gastric Bypass	☐ Parathyroidectomy	☐ Anesthesia Problem Yes
☐ AV Graft	☐ Hemorrhoidectomy	☐ Pneumonectomy	☐ Anesthesia Problem No
☐ Aortic Valve Replacement	☐ Hysterectomy	☐ Prostatectomy	☐ Surgical Complications
☐ Appendectomy	☐ Pain Procedures	☐ PTCA (Angioplasty)	☐ Sx Complications No
☐ B-A-F Bypass	☐ Knee Arthroscopy	☐ R-A-F Bypass	☐ Post op delirium
☐ Back Surgery	☐ Knee Replacement	☐ Rotator Cuff Repair	☐ Other
☐ Bronchoscopy	☐ Kyphoplasty	☐ Spinal Fusion	______________________
☐ CABG	☐ L-A-F Bypass	☐ TURP+	
☐ Carotid Endarterectomy	☐ Lumbar Spinal Fusion	☐ Tonsillectomy	______________________

Family History

☐ FH Alcoholism	☐ FH Breast Cancer	☐ FH Ulcers	☐ FH Melanoma
☐ FH Anemia	☐ FH Cervical Cancer	☐ FH Surgery - Cervical	☐ FH Ovarian Cancer
☐ FH Arthritis	☐ FH Colon Cancer	☐ FH Surgery - Lumbar	☐ FH Uterine Cancer
☐ FH Anesthetic Problems	☐ FH Depression	☐ FH Surgery - Thoracic	☐ FH Other Cancer
☐ FH Anxiety	☐ FH Diabetes	☐ FH Other Diseases	☐ FH Thyroid Disease
☐ FH Asthma	☐ FH Growth/Development	☐ FH CHD male < 55	☐ FH Weight Disorder
☐ FH Back Problems	☐ FH Heart Disease	☐ FH CHD female <65	☐ FH Headaches
☐ FH Birth Defects	☐ FH Angina	☐ FH Colon CA father	☐ FH Other Problems
☐ FH Blood Clots	☐ FH Hypertension	☐ FH Colon CA mother	☐ FH PMS
☐ FH Blood Transfusions	☐ FH High Cholesterol	☐ FH Lung Cancer	☐ FH Endometriosis

Social History

☐ Married	☐ Disabled	☐ Never Smoked	☐ Drug Rehab (Yes)
☐ Divorced	☐ Working	☐ Alcohol Use (Yes)	☐ Regular Exercise (Yes)
☐ Single	☐ Not Working	☐ Alcohol Use (No)	☐ Regular Exercise (No)
☐ Widowed	☐ Seeking Disability	☐ Drug Use (Yes)	☐ Pregnant
☐ Live Alone	☐ Family Stress (Yes)	☐ Drug Use (No)	☐ Date of last menstrual period ______________
☐ Does not live alone	☐ Current Smoker	☐ Substance Abuse (Yes)	
☐ Retired	☐ Former Smoker	☐ Substance Abuse (No)	

Review of Systems

General
- ☐ Weight loss
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever

Eyes
- ☐ Vision loss
- ☐ Double Vision
- ☐ Glasses

ENT
- ☐ Pain/Tearing
- ☐ Hearing loss
- ☐ Dizzy
- ☐ Tooth/Gum Pain

Cardiovascular
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Murmur
- ☐ Shortness of Breath

Respiratory
- ☐ Cough
- ☐ Bronchitis
- ☐ Coughing up blood

GI
- ☐ Trouble swallowing
- ☐ Nausea/vomiting
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody stool
- ☐ Abdominal pain

GU
- ☐ Bloody urine
- ☐ Urgency/incontinence
- ☐ Pain with urination

Musculoskeletal
- ☐ Joint pain
- ☐ Stiffness
- ☐ Limp
- ☐ Spasms
- ☐ Muscle Pain
- ☐ Limited movement

Skin
- ☐ Rash
- ☐ Lumps
- ☐ Redness
- ☐ Itching
- ☐ Swelling

Neurological
- ☐ Seizures
- ☐ Paralysis
- ☐ Fainting
- ☐ Numbness
- ☐ Tingling

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Moodiness

Endocrine
- ☐ Sweating
- ☐ Thirsty
- ☐ Always cold
- ☐ Always hot

Hematology
- ☐ Bleeding
- ☐ Blood Clots

Allergy
- ☐ Uticaria
- ☐ Allergic Rash
- ☐ Hay Fever
- ☐ Recurrent Infections

CURRENT MEDICATIONS *(Please list medications, dosage and how taken)*

Please bring all medications with you to every visit. Thank you.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of the form.

______________________________ ____________________

Signature Date