**NEW PATIENT HISTORY**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT\_\_\_\_\_\_\_\_ft \_\_\_\_\_\_\_\_in WEIGHT \_\_\_\_\_\_\_\_\_lbs

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTERNIST/PCP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARDIOLOGIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER SPECIALIST(S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR YOUR VISIT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LEFT / RIGHT / BOTH

DURATION OF SYMPTOMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MONTHS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEARS

What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following?

Steroid Injections Last Injection\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Viscosupplementation Injections (Synvisc, Orthovisc, Euflexxa, etc) Last Injection \_\_\_\_\_\_\_\_\_ How Many?\_\_\_\_\_\_

Bracing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Therapy How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anti-Inflammatory Medications (past & present - Aleve, Advil, Ibuprofen, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain at night?  Y  N Back Pain  Y  N Daily pain level (1-10)\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN RATING:**

Mild Moderate Severe Totally Disabling

**DO YOU LIMP?**

Slightly Mildly Moderately Severely Unable to Walk

**DO YOU REQUIRE ASSISTANCE?**

None Cane at Times Cane Full Time Walker Wheelchair

**HOW FAR CAN YOU WALK?**

Unlimited 6 Blocks 2-3 Blocks Indoor Only Unable

**CAN YOU CLIMB STAIRS?**

Normally Normally with the Rail Any Method Unable

**CAN YOU PUT ON SOCKS AND SHOES?**

With Ease With Difficulty Unable

**WHAT IS YOUR ACTIVITY LEVEL?**

Bedridden Sedentary Semi-Sedentary Light Labor Moderate/Heavy Labor

**PAST MEDICAL HISTORY**

Have you ever experienced or been told by a doctor that you have any of the following conditions?

Anemia Aneurysm Cardiac Arrhythmia

Blood Clots Carotid Artery Disease Congestive Heart Failure

Cardiac Disease Lung Disease (Emphysema) Diabetes

Gastrointestinal Bleeding GERD/Reflux Hypothyroidism

Heart Valve Disease High Cholesterol High Blood Pressure

Kidney Disease Peptic Ulcer Disease Peripheral Vascular Disease

Stroke/TIA Other Conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Dentures Dental Implants Gum Disease

Most recent dental appointment (MM/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL TREATMENT** (List surgical procedures and year performed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**MEDICATIONS** (List dosage and frequency taken. Attach list if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES REVIEW OF SYMPTOMS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Have you experienced any of the following?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Weight Loss Weight Gain

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Fever/Chills/Sweats Headache

**SOCIAL HISTORY** Visual Changes Recent Cold/Flu

Single Married Shortness of Breath Cough

Retired Employed Wheezing Chest Pain

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Irregular Heart Rate Leg Swelling

Do you smoke tobacco? Y N Abdominal Pain Nausea/Vomiting

Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Painful Urination Urinary Frequency

Do you drink alcohol? Y N UTIs Back Pain

Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Numbness/Tingling Weakness

Interest/Activities \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bleeding Tendencies Bruising