

Office use only
XRAYS

RM-

DEXA-

MID TN BONE AND JOINT CLINIC
NEW PATIENT

Name _____ Date _____ Chart # _____

HT _____ WT _____ BP _____ BIRTHDATE _____ AGE _____

Please circle your work status—Regular Duty Light Duty Not Working Disabled Retired

List any medications to which you are **ALLERGIC** _____

Past Medical/Surgical History (circle all that apply):

Anemia
Arthritis-Rheumatoid or Osteoarthritis
Asthma/Lung Disease
AIDS/HIV+
Kidney Disease-Dialysis or Incontinence
Bleeding Problems
Are you on a blood thinner? Yes or no
Blood Vessel Disease-Where: _____
Blood Clots-DVT: Yes or no When: _____
Where: _____
Cancer--Type _____
Diabetes
Gout
Heart Disease
Hepatitis/Liver Disease
High Blood Pressure
Intestinal/Ulcer Disease
Reflux
High Cholesterol
Back Problems-Neck
Upper back
Lower Back
Problems with Anesthesia
Prostate Problems
Osteoporosis
Stroke
Thyroid Disease

Previous fractures: _____

Bone/Joint Surgery: if yes, please list dates:

Previous Surgery: please give dates if in last 6 mo.

Appendectomy
Back surgery-lower Back _____
Neck _____
Blood Vessel Surgery
Cataracts removed
C Section
Gallbladder removed
Heart Surgery-When: _____
What kind: _____
Pacemaker/Defibrillator
Hernia
Hysterectomy
Lung Surgery
Mastectomy
Prostate Surgery
Tonsillectomy
Tubal Ligation
Other: _____

Did another doctor send you here? _____ Please give name: _____

What is your main reason for seeing the doctor today? _____

How long have you had this problem? _____ If accident, list date and location of injury _____

Is this a work related injury? _____

Have you had any recent xrays, MRI/CT, physical therapy or injections for this problem? _____
If yes, where and when: _____

List any medications you take on a regular basis _____

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Chart

Are you a patient of a pain clinic? _____ If yes, please list name of physician _____

Are you on any narcotic pain medicine? i.e. Darvocet, Lortab, Percocet, Morphine, Demerol, etc. _____

Social History:

Do you smoke? Y or N If yes, how much per day? _____ How many years? _____

Do you use any other tobacco products? Y or N If yes, what kind? _____

Do you drink alcohol? _____

Are you right or left handed? _____ Occupation: _____

Who is your family doctor? _____

Family History-circle all that apply:

Arthritis	Diabetes
Bleeding Problems	Difficulty with Anesthesia
Heart Disease	Kidney Disease
High Blood Pressure	Stroke
Cancer	

Is there a possibility of you being pregnant at this time? _____

Review of Symptoms (circle any symptoms or problems you have):

General:	weight change, fever, fatigue, headaches
Eyes:	eye disease, injury, blurred vision, glaucoma, glasses/contacts
ENT/Mouth:	hearing loss, earaches, sinus problems, mouth sores, voice change
Cardio:	chest pain, shortness of breath, leg swelling
Resp:	coughing, wheezing, spitting up blood
GI:	nausea/vomiting, poor appetite, constipation, rectal bleeding, heartburn
GU:	blood in urine, incontinence, kidney stones, female problems such as irregular periods/abnormal bleeding
MS:	joint pain, stiffness, weakness, difficulty walking
Skin/Hair :	rash, change in hair or nails, varicose veins
Neuro:	dizziness, seizures, head injury, numbness/tingling
Psych:	memory loss, confusion, depression, nervousness
Hemo/Lymph:	bleeding, easy bruising, swollen glands

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INITIALS-

Signature: _____ **Date:** _____

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New Back problem Yes or No

Patient given patient education