

# New Patient Worksheet

# Austin Orthopaedics

Today's Date: \_\_\_\_\_

Your Height: \_\_\_\_\_

Your Weight: \_\_\_\_\_

1. What is the reason for today's visit?

2. Name: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Gender:  M  F

5. Were you sent here by a doctor?  Y  N  
If yes, who was it?

6. Have you had this problem before?  Y  N  
If yes, please describe your symptoms in the past.

7. When did your current symptoms begin?

Are your symptoms related to an injury?  Y  N  
If yes, please give date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have a lawyer?  Y  N  
Describe the injury below.

8. What doctors have you seen for this problem?

9. What medications have you tried?

10. Have you tried

- Chiropractor
- Physical therapy
- Accupuncture
- Massage therapy

Have you received any injections for relief of your pain?  
 Y  N

If yes, what kind of injection was it?

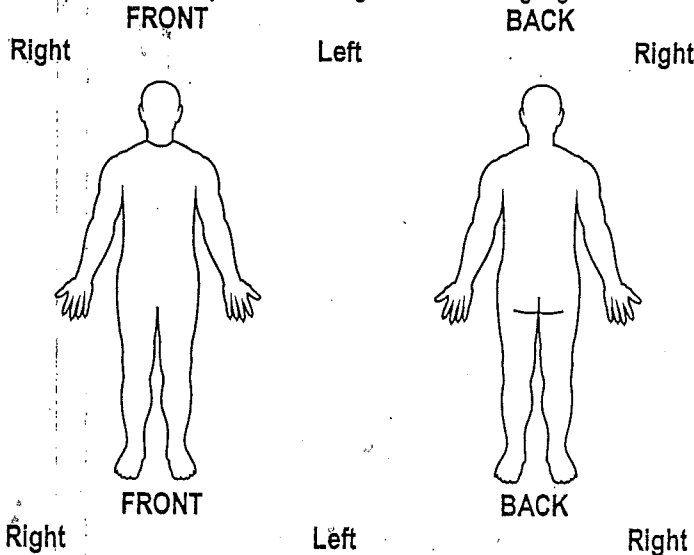
11. What tests have you had to help diagnose your current problem?

- X-rays
- CT Scan
- MRI
- EMG or Nerve Conduction
- Blood work

12. How would you describe your pain now?

- constant
- intermittent
- burning
- stinging
- sharp
- dull
- aching
- throbbing

13. Mark areas where you are having pain with an X.  
Mark areas where you are having numbness/tingling with an O.



14. Please rate your pain now.

None 0 1 2 3 4 5 6 7 8 9 10 Worst ever

15. Please rate your pain at its worst.

None 0 1 2 3 4 5 6 7 8 9 10 Worst ever

16. What makes your pain worse?

- rest
- lifting
- lying down
- bending
- sitting
- twisting
- standing
- coughing
- walking
- sneezing
- nothing
- everything
- other, explain \_\_\_\_\_

17. What makes your pain better?

- rest
- sitting
- standing
- moving around
- exercise
- lying down
- ice/heat
- nothing
- medications, names \_\_\_\_\_
- other, explain \_\_\_\_\_

18. Do you have any of the following?

- Pain wakes from sleep  N  Y
- Numbness  N  Y
- Tingling  N  Y
- Weakness  N  Y
- Inability to urinate  N  Y

Medical History Form

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_ Referring Dr. \_\_\_\_\_

N4,5  
E5  
(1)

Medical History: (Write P for Past and C for Current Problem)

- |                                                    |                                                      |                                                |                                                 |
|----------------------------------------------------|------------------------------------------------------|------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Mental Health Disorder |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Menopause                   | <input type="checkbox"/> Rheumatoid Arthritis  | <input type="checkbox"/> HIV / AIDS             |
| <input type="checkbox"/> Blood Clots / DVT         | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Bleeding Disorder      |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Thyroid Trouble             | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Anemia                 |
| <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Ulcers / Reflux Disease   | <input type="checkbox"/> Parathyroid Trouble         | <input type="checkbox"/> Drug or Alcohol Abuse | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Liver Disease / Hepatitis | <input type="checkbox"/> Sickle Cell Trait / Disease | <input type="checkbox"/> Depression            | _____                                           |

Surgical History Procedure(s) and Date(s):

_____	_____	_____
_____	_____	_____
_____	_____	_____

N3E4  
(1)

Medications (Including dosage and frequency):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies and Reaction: \_\_\_\_\_ Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reaction to anesthesia: Yes  No   
(If yes, describe reaction)

FH  
N4,5  
E5  
(1)

Family History: If any of your blood relatives have had any of the following conditions, check the box:

- |                                              |                                              |                                               |                                           |                                            |
|----------------------------------------------|----------------------------------------------|-----------------------------------------------|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Muscle Disorders | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Nerve Disorders  | <input type="checkbox"/> Other             |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Blood Disease    |                                            |

SH  
N4,5  
E5  
(1)

Social History:

Tobacco Use:  Current Smoker  Former Smoker  Non Smoker #Packs/Day \_\_\_\_\_ #Years \_\_\_\_\_ Year Quit \_\_\_\_\_

Alcohol Use:  Never  Rarely  Weekly  Daily

Marital Status:  Married  Single  Divorced  Widowed

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

ROS  
N2E3  
(M/S)

Have you had problems with the same orthopedic problem that you are being seen for now? \_\_\_Yes\_\_\_ No  
Explain if "yes" \_\_\_\_\_

N3E4  
(2+)

Do your other joints have: (Circle Y=yes or N=no)

Morning stiffness	Y N	Joint pain	Y N	Joint swelling	Y N
Do you have problems with any of the following: (Circle Y=yes or N=no)					
Recurring fever	Y N	Decreased appetite	Y N	Dry skin	Y N
Recent weight loss	Y N	Difficulty swallowing	Y N	Skin lesions	Y N
Headaches	Y N	Heartburn	Y N	Skin	Y N
Worsening vision	Y N	Nausea	Y N	Bleed easily	Y N
See double images	Y N	Vomiting	Y N	Bruise easily	Y N
Blurry vision	Y N	Abdominal pain	Y N	Dizziness	Y N
Loss of hearing	Y N	Blood in stool	Y N	Convulsions	Y N
Hoarseness	Y N	Painful urination	Y N	Sleep disturbance	Y N
Chest pain/discomfort	Y N	Increased need to urinate	Y N	Drug addiction	Y N
Heart Palpitations	Y N	Blood in urine	Y N	Alcohol addiction	Y N
Difficulty breathing	Y N	Excessive thirst	Y N	Depression	Y N
Chronic cough	Y N	Temperature intolerance	Y N		

N4,5  
E5  
(10)

Give details for any "yes" answer: \_\_\_\_\_

For Office Use Only: New Patient form reviewed by _____ Date _____				Date _____			
Date Reviewed	Change Y or N	Clinical Staff	Physician	Date Reviewed	Change Y or N	Clinical Staff	Physician
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____