

## **NEW PATIENT MEDICAL HISTORY FORM**

Pati	ent Name:						He	ight:			Weight:		
Rac						Caucasian							
	O Unkr	own	0	Decli	ne to Answe	er							
Ethi	nicity: O H	ispar	nic O	No	n-Hispanic	O Unknow	n 🤇	Decl	ine t	o Answer			
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	Elbow	0			Left	Thigh	0			Left	Mid Back	0	
	Forearm	0	Right	0	Left	Knee	0		4	Left	Low Back	0	
	Wrist	0	Right	Ö	Left	Lower Leg	0	Right	0	Left	Buttocks	0	
	Hand	0	Right	0	Left	Ankle	0	Right	0	Left	Tail Bone	0	
	Thumb	0	Right	0	Left	Foot	0	Right	0	Left			
	Index	0	Right	0	Left	Great Toe	0	Right	0	Left			
	Middle	0	Right	0	Left	2nd Digit	0	Right	0	Left			
	Third	0	Right	0	Left	3rd Digit	0	Right	0	Left			
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	Treating I	ER: (6	ex. St. Lu	ke's	Health)				1	Date: (mm/de	d/vvvv)		

5. Rate the pain (10 being the most  0 1 2 6. Do the symptoms wake you fro Yes No 7. Please describe the symptoms: Sharp Dull 8. What is the timing of the sympto Constant Interm 9. Is the problem getting better or v Getting better Getting better Walking 10. What makes the symptoms wors Squatting Kneeling S Running Walking 11. Are there any other symptoms a Redness Bruising Popping Ting  Prior Testing / Treatment Have you had any prior tests for this None X-rays MRI	Do the symptoms wake you from sleep?  Yes No  Please describe the symptoms: Sharp Dull Stabbing Throbbing Aching Burning Shooting  What is the timing of the symptoms? Constant Intermittent (comes and goes)  Is the problem getting better or worse? Getting better Getting worse Unchanged  What makes the symptoms worse? Squatting Kneeling Sitting Bending Stairs Twisting Moving Lying in bed Running Walking Athletics Standing Gripping Lifting Reaching Overhe  Are there any other symptoms associated with this problem? Redness Bruising Swelling Numbness Stiffness Limping Clicking Locking Popping Tingling Weakness Giving way  Or Testing / Treatment  ve you had any prior tests for this problem? None X-rays MRI CT Scan Nerve Test (EMG/NCV) Bone Scan  ve you had any prior treatment for this problem? Yes No  ve of treatment Status of symptoms after treatment (select only those that apply) Date of treatment    Improved Worsened Unchanged		ness (continued)			
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Patient Name:

Page 2

Aneur	ysm (Brain) Surgery	Hysterectomy		Orthopedic on	side:	Right	Left
Aortic	Bypass / Vascular Surgery	○ LAPBand/Gastric Byp	ass Surgery	Arthroscopy: K	nee	0	0
Apper	ndectomy	O Lumpectomy		Arthroscopy: SI		0	0
Catara	act (Eye) Surgery	O Mastectomy	90788877 1777887774788657647547534734473447744657543344744	Carpal Tunnel F	Release	0	0
Choled	cystectomy (Gallbladder)	Malignancy/Cancer		Rotator Cuff Re	pair	0	0
Heart	Surgery	<ul><li>Stents</li></ul>		Total Hip Repla	acement	0	0
Hernia	a Repair			Total Knee Rep	lacement	0	.0
			and the second s	TotalShoulderR	eplacement	: 0	0
				Spinal Surgery	- Indicate Le	evel:	
ark all th	at currently apply:						
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re you tak eview of	king blood thinners?  Systems			in the last 6 mo			Sn
e you tak	king blood thinners?  Systems	Yes No		in the last 6 mo	nths? None for al		
e you tak eview of ease indi	sing blood thinners?  Systems	Yes No		in the last 6 mo	nths? None for al	I	
e you tak eview of ease indi	Systems cate if you have experience.	Yes No	symptoms	in the last 6 mo	nths? None for all	I	
e you take eview of ease indi	Systems cate if you have experience  Weight Loss	Yes No enced any of the following Loss of Appetite	symptoms  Fatigue  Vision	in the last 6 mo	None C	I	
e you take eview of ease indi	Systems  cate if you have experience  Weight Loss  Blurred Vision	Yes	symptoms  Fatigue  Vision	in the last 6 mo	nths? None for all	I	
e you take eview of ease indi	Systems Cate if you have experience  Weight Loss Blurred Vision Hearing Loss	Yes No  enced any of the following  Loss of Appetite Double Vision Hoarseness	symptoms  Fatigue Vision Trouble	in the last 6 mo	None C	I	
e you take eview of ease indi	Systems Cate if you have experience  Weight Loss Blurred Vision Hearing Loss Chest Pain	<ul> <li>Yes No</li> <li>No</li> <li>enced any of the following</li> <li>Loss of Appetite</li> <li>Double Vision</li> <li>Hoarseness</li> <li>Palpitations</li> </ul>	symptoms  Fatigue Vision Trouble Shortn	in the last 6 mo	None for all	I	
e you take eview of ease indi	Systems Cate if you have experience  Weight Loss Blurred Vision Hearing Loss Chest Pain Chronic Cough	<ul> <li>Yes No</li> <li>No</li> <li>enced any of the following</li> <li>Loss of Appetite</li> <li>Double Vision</li> <li>Hoarseness</li> <li>Palpitations</li> <li>Pneumonia</li> </ul>	symptoms  Fatigue Vision Trouble Shortn Blood	in the last 6 mo  Loss e Swallowing ess of Breath	None for all	I	
e you take eview of ease indi	Systems Cate if you have experience  Weight Loss Blurred Vision Hearing Loss Chest Pain Chronic Cough Heartburn, Ulcers	Penced any of the following  Loss of Appetite  Double Vision  Hoarseness  Palpitations  Pneumonia  Nausea, Vomiting	symptoms  Fatigue Vision Trouble Shortn Blood	in the last 6 mo Loss e Swallowing ess of Breath in Stool	None for all	I	
eview of ease indi  CON CON CON CON CON CON CON CON CON CO	Systems Cate if you have experience  Weight Loss Blurred Vision Hearing Loss Chest Pain Chronic Cough Heartburn, Ulcers Painful Urination	<ul> <li>Yes No</li> <li>No</li> <li>enced any of the following</li> <li>Loss of Appetite</li> <li>Double Vision</li> <li>Hoarseness</li> <li>Palpitations</li> <li>Pneumonia</li> <li>Nausea, Vomiting</li> <li>Blood in Urine</li> </ul>	symptoms  Fatigue Vision Trouble Shortn Blood Kidney	in the last 6 mo	None for al	I	Sno
eview of ease indi  CON CON CON CON CON CON CON CON CON CO	Systems Cate if you have experience  Weight Loss Blurred Vision Hearing Loss Chest Pain Chronic Cough Heartburn, Ulcers Painful Urination Frequent Rashes	Palpitations Preumonia Nausea, Vomiting Skin Ulcers	symptoms  Fatigue Vision Trouble Shortn Blood Kidney Lumps	in the last 6 mo Loss Example Loss Example Swallowing Example Control of the last 6 mo Problems Problems Problems Problems	None for al	I	
re you take eview of lease indi L) CON 2) EYE 3) ENT 4) CV 5) RS 6) GI 7) GU 8) SK	Systems Cate if you have experience  Weight Loss Blurred Vision Hearing Loss Chest Pain Chronic Cough Heartburn, Ulcers Painful Urination Frequent Rashes Frequent Falls	Palpitations Pneumonia Nausea, Vomiting Blood in Urine Skin Ulcers Loss of Coordination	symptoms  Fatigue Vision Trouble Shortn Blood Kidney Lumps Numbr Dizzine	in the last 6 mo Loss Example Loss Example Swallowing Example Control of the last 6 mo Problems Problems Problems Problems	None for al	I	
re you tak eview of	Systems Cate if you have experience  Weight Loss Blurred Vision Hearing Loss Chest Pain Chronic Cough Heartburn, Ulcers Painful Urination Frequent Rashes Frequent Falls Change in Bowel	Preumonia Nausea, Vomiting Blood in Urine Skin Ulcers Loss of Coordination Change in Bladder	symptoms  Fatigue Vision Trouble Shortn Blood Kidney Lumps Numbr Dizzine	in the last 6 mo  Loss  E Loss  E Swallowing  Ess of Breath  in Stool  Problems  Psoriasis  ness  Ess  Disorder	None C	I	

Patient Name: \_\_\_\_\_

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Have any d	irect relatives had any of t	ho fo	allowing disorders				
Father	None	0	Diabetes	0	None for all Heart Disease	77	Uhandanian
	Bleeding Problems			0		0	
	Stroke	0	Osteoporosis			0	Muscular Dystrophy Cancer
	Comments (ex. cancer ty	The same of the sa	Osteopol Os.	Part .	Mileumatora Artificia	Sant Contract	Cancer
Mother	O None	0	Diabetes	0	Heart Disease	0	Hypertension
	Bleeding Problems	0	Epilepsy	0	Connective Tissue	0	Muscular Dystrophy
	○ Stroke	0	Osteoporosis	0			Cancer
	Comments (ex. cancer ty	p <u>e)</u>					Carroca
Sibling	O None	0	Diabetes	0	Heart Disease	0	Hypertension
	<ul> <li>Bleeding Problems</li> </ul>	0	Epilepsy	0	Connective Tissue	Ö	Muscular Dystrophy
	O Stroke	0	Osteoporosis	0	Rheumatoid Arthritis	0	Cancer
	Comments (ex. cancer type	p <u>e)</u>					
Marital Statu	k alcohol? Daily us: Married Single cently working? Yes	Occa D	ivorced Widow	y O	Domestic Partnership		vork?
Marital Statu Are you curr Please list wo	k alcohol? Daily us: Married Single Crently working? Yes ork restrictions, if any:	Occa D No	nsionally Rarel vivorced Widow ORetired Disa	y C ved C abled If	Domestic Partnership no, what date did you l	ast v	
Marital Statu Are you curr Please list wo	k alcohol? Daily us: Married Single Crently working? Yes ork restrictions, if any:	Occa D No	nsionally Rarel vivorced Widow ORetired Disa	y C ved C abled If	Domestic Partnership	ast v	vork? udent
Marital Statu Are you curr Please list wo Occupation:	k alcohol? Daily us: Married Single crently working? Yes ork restrictions, if any:	Occa D No	esionally Rarel  Nivorced Widow Retired Disa Employer:	y owed owed if	Domestic Partnership no, what date did you I  the pain is the wor	Stu	udent

Page 4 Patient Name:

edication, Relevant Food, or		ction
NAME OF THE OWNER OWNER OF THE OWNER OWNE		
_atex allergy? O Yes O N	lo	
l'alallandiani	la an annula design	lone
ease list all medications you ta		lone
Medication	Dosage and Frequency (e.g	. 20 mg, once/day)
		None
o you have a personal history o	_ C Emphysema	Kidney Disease
Aneurysm Where: Angina (Chest Pain)	<ul><li>Emphysema</li><li>Epilepsy</li></ul>	<ul><li>Kidney Disease</li><li>Kidney Stones</li></ul>
Aneurysm Where: Angina (Chest Pain) Arthritis Type:	Emphysema Epilepsy Heart Attack	<ul><li>Kidney Disease</li><li>Kidney Stones</li><li>MRSA Infection</li></ul>
Aneurysm Where: Angina (Chest Pain) Arthritis Type: Asthma	<ul><li>Emphysema</li><li>Epilepsy</li><li>Heart Attack</li><li>Hepatitis Type:</li></ul>	<ul><li>Kidney Disease</li><li>Kidney Stones</li><li>MRSA Infection</li><li>Pacemaker</li></ul>
Aneurysm Where: Angina (Chest Pain) Arthritis Type: Asthma Bone or Joint Infections	Emphysema Epilepsy Heart Attack Hepatitis Type: HIV / AIDS	<ul> <li>Kidney Disease</li> <li>Kidney Stones</li> <li>MRSA Infection</li> <li>Pacemaker</li> <li>Phlebitis (Blood Clots)</li> </ul>
Aneurysm Where: Angina (Chest Pain) Arthritis Type: Asthma Bone or Joint Infections Cancer Type:	Emphysema Epilepsy Heart Attack Hepatitis Type: HIV / AIDS High Cholesterol	<ul> <li>Kidney Disease</li> <li>Kidney Stones</li> <li>MRSA Infection</li> <li>Pacemaker</li> <li>Phlebitis (Blood Clots)</li> <li>Pulmonary Embolism</li> </ul>
Aneurysm Where: Angina (Chest Pain) Arthritis Type: Asthma Bone or Joint Infections Cancer Type: Chemotherapy / Radiation	Emphysema Epilepsy Heart Attack Hepatitis Type: HIV / AIDS High Cholesterol Hypertension	<ul> <li>Kidney Disease</li> <li>Kidney Stones</li> <li>MRSA Infection</li> <li>Pacemaker</li> <li>Phlebitis (Blood Clots)</li> <li>Pulmonary Embolism</li> <li>Reaction to Anesthesia Type:</li> </ul>
Aneurysm Where: Angina (Chest Pain) Arthritis Type: Asthma Bone or Joint Infections Cancer Type: Chemotherapy / Radiation COPD	Emphysema Epilepsy Heart Attack Hepatitis Type: HIV / AIDS High Cholesterol Hypertension Hyperthyroidism	<ul> <li>Kidney Disease</li> <li>Kidney Stones</li> <li>MRSA Infection</li> <li>Pacemaker</li> <li>Phlebitis (Blood Clots)</li> <li>Pulmonary Embolism</li> <li>Reaction to Anesthesia Type:</li> <li>Seizures</li> </ul>
Aneurysm Where: Angina (Chest Pain) Arthritis Type: Asthma Bone or Joint Infections Cancer Type: Chemotherapy / Radiation	Emphysema Epilepsy Heart Attack Hepatitis Type: HIV / AIDS High Cholesterol Hypertension Hyperthyroidism Hypothyroidism	Kidney Disease Kidney Stones MRSA Infection Pacemaker Phlebitis (Blood Clots) Pulmonary Embolism Reaction to Anesthesia Type: Seizures Stomach Ulcers
Aneurysm Where: Angina (Chest Pain) Arthritis Type: Asthma Bone or Joint Infections Cancer Type: Chemotherapy / Radiation COPD	Emphysema Epilepsy Heart Attack Hepatitis Type: HIV / AIDS High Cholesterol Hypertension Hyperthyroidism	<ul> <li>Kidney Disease</li> <li>Kidney Stones</li> <li>MRSA Infection</li> <li>Pacemaker</li> <li>Phlebitis (Blood Clots)</li> <li>Pulmonary Embolism</li> <li>Reaction to Anesthesia Type:</li> <li>Seizures</li> </ul>

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Signature
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