EmergeOrtho

New Patient Form

Patient Full Name: _____ Date of Birth _____/_____/____

Gender _____ Ht: _____ Wt: _____ S.S.#_____

Phone: (_____)_____ Email: _____ _____

Address: _____City_____ State____ Zip_____

Referring Physician: _____ Primary Care: _____

Pharmacy Name: _____ Phone: _____

Reason for Visit: _____ Date of Injury: _____ Pain Scale (1-10): ____

Allergies

List Drug Allergies and Reactions: ☐ None _____

_____

Medications: Name, Strength, Dose

Please list below or provide list to staff

Medicine	Dose	#/ Day	Medicine	Dose	#/ Day

Have you had a pneumonia vaccine? ____ No ____ Yes If yes, date of vaccine: _____

Have you had a Flu Shot in the last year? ____ No ____ Yes If yes, date of shot:_____

Have you had any falls in the last year? ____ No ____ Yes If yes, how many: _____ Were you injured? ___ No ___ Yes

Family History

Please list any blood relatives (Mother, Father, Siblings) that have had any of the following:

Arthritis: _____ Bleeding Problems: _____ Stroke: _____

Heart Disease: _____ Diabetes: _____ Cancer: _____

High Blood Pressure: _____ Kidney Disease: _____ Other: _____

Social History

Occupation: _____ Marital Status: SINGLE MARRIED WIDOWED OTHER

Dominate hand: RT LT Recreational Drugs: YES NO Alcohol: NEVER RARELY WEEKLY DAILY

Tobacco Use: YES NO QUIT Year Quit: _____ # Packs/Day: ____ # Years: ___ Chewing Tobacco: YES NO

Age of Menopause: _____ Current Hormone Therapy: YES NO

Advance directive: YES NO

Medical Power of Attorney: YES NO

Past Surgeries

List Surgery Type, Date, and Physician who performed the surgery:

_____ _____

_____ _____

_____ _____

Past Medical History

☐ ADD/ADHD	☐ Alzheimer's Disease	☐ Anemia	☐ Anxiety
☐ Arthritis	☐ Asthma	☐ Bipolar	☐ Bleed or Bruise Easily
☐ Bleeding Disorder	☐ Blood Clots	☐ Emphysema/COPD	☐ CPAP
☐ Cancer	☐ Cardiac Defib	☐ Chest Pain/Angina	☐ Chronic Back Pain
☐ Claustrophobia	☐ Stomach Ulcers/Colitis	☐ Congestive Heart Failure	☐ Defibrillator
☐ Depression	☐ Diabetes	☐ Dizziness	☐ Drug Dependency/Abuse
☐ Enlarged Glands	☐ Excessive Thirst	☐ Eye Disease/Cataracts/Glaucoma	☐ Fibromyalgia
☐ GERD/Reflux	☐ GI Issues	☐ Gout	☐ HIV/AIDS
☐ Headaches	☐ Heart Attack	☐ Heart Problems	☐ Hepatitis/Liver Disease
☐ High Cholesterol	☐ Hypertension	☐ Irregular Heartbeat	☐ Joint Pain
☐ Kidney Disease	☐ Leukemia	☐ Loss of Consciousness	☐ Lung Disease
☐ Lupus/SLE	☐ MRSA	☐ Migraines	☐ Mouth Sores
☐ Numbness/Tingling	☐ Osteoarthritis	☐ Osteoporosis	☐ Pacemaker
☐ Parkinson's Disease	☐ Poor Circulation	☐ Previous Cortisone Injection	☐ Previous Fracture
☐ Psoriasis	☐ Pulmonary Embolism	☐ Previous Oral Steroid	☐ Rheumatoid Arthritis
☐ Seizures/Epilepsy	☐ STD	☐ Sickle Cell Anemia	☐ Sleep Apnea
☐ Spitting up Blood	☐ Stroke	☐ Swelling of Legs/Feet/Hands	☐ Thyroid Disorder
☐ Tuberculosis	☐ Urinary Infection	☐ Weight Loss	☐ Change in Hair or Nails

Review of Systems

Please check any of the below that you have had in the last month.

Constitutional: ☐ Fever ☐ Significant Weight Loss/Gain - How many pounds? _____

Heent: ☐ Dry Eyes ☐ Eye Irritation ☐ Vision Changes ☐ Sore Throat

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Poor Circulation ☐ Leg Swelling

Respiratory: ☐ Cough ☐ COPD ☐ Asthma ☐ Shortness of Breath

Gastrointestinal: ☐ Vomiting ☐ Blood in Stool ☐ Diarrhea ☐ Vomiting Blood ☐ Nausea ☐ Constipation

Genitourinary: ☐ Blood in urine ☐ Difficulty Urinating ☐ Burning during urination

Musculoskeletal: ☐ Joint Pain ☐ Swelling in Joints ☐ Rheumatoid Arthritis ☐ Height Loss of 2 inches or more

Skin: ☐ Rash ☐ Varicose Veins

Neurologic: ☐ Numbness ☐ Seizures ☐ Dizziness ☐ Difficulty with Balance ☐ Tingling

Psychiatric: ☐ Anxiety ☐ Depression

Endocrine (Temperature Intolerance): ☐ To Heat

Hematologic/ Lymphatic: ☐ Anemia ☐ Swollen Glands ☐ Bruising ☐ Bleed Easily

Patient Signature: _____ Date: _____