Ortho New Patient Form

Patient Name: _____________________________ Date of Birth: _________________Today's Date:_________________

Referring Physician: _______________________________Primary Care:____

Reason for Visit:____Date of Injury:_______________

Review of Systems: Circle any of the following you are currently experiencing.

Constitutional
Fever
Weight Gain
Weight Loss

HEENT
Dry Eyes
Eye Irritation
Vision Changes
Sore Throat

Cardiovascular
Chest Pain/Angina
Palpitations
Poor Circulation
Leg Swelling

Respiratory
Cough
Shortness of Breath
COPD
Asthma

Gastrointestinal
Nausea Vomiting
Black Stools/Blood in Stool
Diarrhea
Vomiting Blood

Genitourinary
Blood in Urine
Difficulty Urinating

Musculoskeletal
Joint Pain
Joint Swelling
Rheumatoid Arthritis
Lost 2 or more inches in Height

Integumentary
Rash
Varicose Veins

Neurologic
Numbness
Seizures
Dizziness
Problems with Balance

Psychiatric
Anxiety
Depression

Endocrine
Heat Intolerance

Hematologic/Lymphati
Anemia
Bleed Easily
Bruise Easily
Swollen Glands

Please list Allergies and Reaction (Food, Medication, Tape, or Betadine)____
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Pharmacy Name and Number: ____

Medications: Name, Strength and Dose

Medicine	Dose	#/ Day	Medicine	Dose	#/ Day

Recent X-ray/MRI/CT, if so, where and when:____
Recent Bone Density ______________________ Recent Lab work, if so, where and when _________________________

Past Surgical History: Type and Date

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

Family History: Please list any blood relatives (mother, father, siblings, aunt, uncle, grandparents) that have had any of the following.

Arthritis__________________ Bleeding Problems_______________ Stroke_________________________

Heart Disease_____________ Diabetes______________________ Cancer_________________________

Other____________________ High Blood Pressure_____________ Kidney Disease______________________

Social History: Occupation__________ Tobacco: YES NO QUIT How much?____ Chewing Tobacco: YES NO

Recreational Drugs: YES NO Alcohol: Yes NO Right Hand or Left hand Dominance:_____________

Height _____ft______in Weight_____Lbs Age Of Menopause________ Current Hormone Therapy*:* NO YES

Past Medical History - Ortho

Please circle if you have ever had any of the following conditions:

Anemia	Gout	MRSA
Asthma	Headaches	Osteoporosis
Blood Clots	Heart Attack (MI)	Pacemaker
Cancer	Heart Problems	Previous Oral Steroids(s)
Claustrophobia	Hepatitis/Liver Disease	Psoriasis
Colitis/Stomach ulcers	High Cholesterol	Seizures/Epilepsy
Depression	HIV/AIDS	Sleep Apnea
Diabetes	Hypertension	Stroke/TIA
Drug Dependency/Abuse	Joint Pain	Swelling of Legs/Feet/Hands
Emphysema/COPD	Kidney Disease	Thyroid Problems/Goiter
Eye Disease/Cataracts/Glaucoma	Leukemia	Tuberculosis
Fibromyalgia	Lung Disease	Weight Loss
GERD/Reflux	Lupus/SLE	

Comments: ____

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