

## New Patient Medical History

Welcome, and thank you for choosing the Longmont Clinic and Dr. Shah for your orthopedic care. Please take the time to answer the following questions as completely as possible so that we may better serve you.

### DEMOGRAPHICS

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female  
 Occupation: \_\_\_\_\_ Are you?  Right-handed  Left-handed  
 Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### HISTORY OF PRESENT ILLNESS

Height: \_\_\_\_ ft. \_\_\_\_ in. Weight: \_\_\_\_ lbs.

Why are you here today? \_\_\_\_\_

Location: \_\_\_\_\_ Where is the pain/problem? Does it travel to other areas? Quality: \_\_\_\_\_ Is the pain dull, sharp, throbbing, achy, burning?

Severity: \_\_\_\_\_ How severe is the pain on a scale of 1 – 10 with 10 being the most severe? Duration: \_\_\_\_\_ How long have you had this pain/problem?

Timing: \_\_\_\_\_ Is the pain rare, constant, intermittent? Daily, weekly, or monthly? Context: \_\_\_\_\_ Is the pain/problem associated with any specific activities?

Associated Symptoms: \_\_\_\_\_ Are there any other associated problems such as numbness, tingling, cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain, etc.?

Modifying Factors: \_\_\_\_\_ Are there any activities or modifications that make the pain/problem worse or better?

What diagnostic tests have you had:  X-Ray  MRI  CT  EMG/NCS  Blood Test  Other \_\_\_\_\_

What treatments have you had:  Anti-inflammatory  Physical Therapy  Injection  Surgery  Other \_\_\_\_\_

Please list any hobbies/sports you enjoy: \_\_\_\_\_

### PAST MEDICAL HISTORY

Do you currently have or ever had any of the following? Please check all pertinent boxes:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Stomach Ulcer/Acid Reflux |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> DVT/Blood Clot in Legs    |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> PE/Blood Clot in Lungs    |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Sleep Apnea     | <input type="checkbox"/> Other _____               |

### ALLERGIES

Do you have any allergies to drugs, latex, or tape?  No  Yes  
 Allergen \_\_\_\_\_ Reaction: \_\_\_\_\_  
 Allergen \_\_\_\_\_ Reaction: \_\_\_\_\_

**Please complete the other side of this form.**

Patient's Signature \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICATIONS**

Please list any medications you are currently taking. Include non-prescription medicines and supplements.

NAME OF DRUG	DOSE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

**PAST SURGICAL HISTORY**

Type of Surgery	Date	Doctor	City/State

**SOCIAL HISTORY**

**Marital Status**

- Single
- Married
- Divorced
- Widowed

**Alcohol Use**

- Never
- Rarely
- Moderately
- Daily

**Tobacco Use**

- Never
- Previous, but quit
- Currently \_\_\_\_\_ packs per day

**FAMILY MEDICAL HISTORY**

Age	Medical Problems	Age at Death	Cause
Father _____			
Mother _____			
Siblings _____			

Do you have any blood relatives who have or had:  Bleeding Tendency  Difficulty with Anesthesia  Blood Clots

**REVIEW OF SYSTEMS**

Please circle all that apply:

<b>Constitutional</b>		<b>Respiratory</b>		<b>Cardiovascular</b>		<b>Hematologic</b>	
Recent poor health	No Yes	Frequent coughing	No Yes	Chest pain	No Yes	Anemia	No Yes
Fatigue	No Yes	Shortness of breath	No Yes	Leg swelling	No Yes	Bleeding tendency	No Yes
Fevers/Chills	No Yes	Wheezing	No Yes	Palpitations	No Yes	Easy bruising/bleeding	No Yes
Weight change	No Yes					Past transfusions	No Yes
<b>Eyes/Ears/Nose/Throat</b>		<b>Gastrointestinal</b>		<b>Neurological</b>		<b>Musculoskeletal</b>	
Blurred or double vision	No Yes	Change in appetite	No Yes	Headaches	No Yes	Joint pain	No Yes
Glasses/contact lenses	No Yes	Nausea/vomiting	No Yes	Dizziness	No Yes	Joint stiffness	No Yes
Hearing loss or ringing	No Yes	Abdominal pain	No Yes	Numbness/tingling		Muscle weakness	No Yes
Sinus problems	No Yes	Diarrhea/constipation	No Yes			Cold extremities	No Yes
Nose Bleeds	No Yes	<b>Genitourinary</b>		<b>Mental Status</b>		<b>Endocrine</b>	
Sore throat	No Yes	Blood in urine	No Yes	Confusion or memory loss	No Yes	Heat or cold intolerance	No Yes
<b>Integument/Skin</b>		Frequent urination	No Yes	Depression	No Yes	Increased thirst	No Yes
Rash	No Yes	Painful urination	No Yes	Insomnia	No Yes		
Abnormal hair loss	No Yes	Kidney stones	No Yes				
		<b>Any other concerns (please list):</b>	_____				

Patient's Signature \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_