New Patient Initial Evaluation

Name:_____
Age;_____ **D.O.B**:_____

Were you referred by another physician?_Y_N
(If yes, please provide name and phone number)
_____

Where is your pain/ailment? (circle)
Which side: RIGHT LEFT BOTH

Neck Back Shoulder Elbow Hand/Wrist

Hip Knee Calf Ankle Foot

Problems (circle all that apply)

Pain Weakness Instability Locking Swelling Stiffness

Date of Injury or onset of symptoms:_____

How did problem start:_____
_____

Diagnosis if known:_____

Rate your pain (0=none, 10=worst)
At best 0 1 2 3 4 5 6 7 8 9 10
At worst 0 1 2 3 4 5 6 7 8 9 10

Pain at night: Yes No
Does the pain wake you from sleep? Yes No

What makes pain better? _____
_____

What makes pain worse? _____
_____

Is pain getting better, worse, or staying the same?
What does the pain prevent you from doing? _____
_____
_____

Date: _____

Previous treatments for this problem: (circle)

Physical Therapy Activity Modification Injections
Surgery Medications (please see below)
Other:_____

OTC Medications:_____
Rx Medications:_____

What previous imaging studies have been done:
(please give dates)_____
_____

Please list all orthopedic surgeries:_____
_____
_____

Past Medical History:

Heart Problems	Yes No	_____
Stomach Problems	Yes No	_____
Diabetes	Yes No	_____
Liver Problems	Yes No	_____
Kidney Disease	Yes No	_____
Blood Clots	Yes No	_____

Other:_____

Social History:
Do you drink alcohol? Yes No
If yes, how often?_____
Do you smoke/chew tobacco? Yes No
If yes, how often?_____

Allergies to medications? Yes No
List:_____
_____

Please list all medications you are currently taking:_____
_____
_____

Mark Adickes, M.D. Date

Who is your primary care physician:_____Phone:

REVIEW OF SYSTEMS: (Check all that you have experienced recently)

General

- □ Weight loss
- □ Weight gain
- □ Poor appetite
- □ Chills
- □ Fever
- □ Night sweats

Skin

- □ Rash
- □ Hives
- □ Lesions

Head/Eyes/Ears/Nose/Throat

- □ Hay fever
- □ Postnasal drip
- □ Hoarseness
- □ Visual problems
- □ Nose bleeds
- □ Neck stiffness/pain

Psychiatric

- □ Anxiety
- □ Depression
- □ Other _____

_____

_____

Pulmonary

- □ Shortness of breath
- □ Wheezing
- □ Coughing
- □ Coughing up blood

Genitourinary

- □ Frequent urination (frequency)
- □ Urgent urination (urgency)
- □ Painful urination (dysuria)
- □ Need to awaken to urinate
- □ Blood in urine
- □ Penile or vaginal discharge
- □ Kidney stone pain

Gastrointestinal

- □ Indigestion
- □ Gas
- □ Nausea
- □ Vomiting
- □ Vomiting blood
- □ Yellow skin
- □ Abdominal pain
- □ Constipation
- □ Diarrhea
- □ Black stools
- □ Rectal bleeding

Musculoskeletal

- □ Pain
- □ Swelling
- □ Redness
- □ Limited motion
- □ Weakness
- □ Atrophy
- □ Cramps
- □ Popping
- □ Locking/catching
- □ Stiffness
- □ Numbness
- □ Tingling
- □ Mass
- □ Deformity

Lymphatics

- □ Lymph node swelling
- □ Node tenderness

Endocrine

- □ Excessive urination
- □ Excessive thirst
- □ Excessive appetite
- □ Hot intolerance
- □ Cold intolerance
- □ Easy bleeding

Cardiovascular

- □ Chest pain (angina)
- □ Palpitations (rapid heartbeat)
- □ Irregular heartbeat (arrhythmia)
- □ Rheumatic fever
- □ Swollen ankles (pedal edema)
- □ Shortness of breath on exertion
- □ Shortness of breath at night

Neurological

- □ Loss of consciousness
- □ Headaches
- □ Dizziness
- □ Seizures (fits)
- □ Fainting spells

Height _____

Weight _____

Dominance

- □ Right Hand
- □ Left Hand

FAMILY HEALTH Have blood relatives ever had any of the following? If so, indicate their relationship to you (e.g. Diabetes – maternal grandmother)

- □ Diabetes
- □ Tuberculosis
- □ Heart Trouble
- □ Liver Trouble
- □ High Blood Pressure
- □ Any Unusual Disease
- □ Arthritis
- □ Cancer
- □ Blood Disease
- □ Psychiatric Disease
- □ Unusual Reaction to Anesthesia
- □ Stroke

If your mother, father or any of your brothers and/or sisters have died, what was the cause of their death and what was the age at the time of death?_____

_____

_____

I certify that the information provided above is true.

_____ _____

Signature Date

Relationship: __Self
__Parent or Legal Guardian
__Other:_____
(*Please Specify*)

Physician Notes:_____

_____

Signature:_____**Date:**_____