Valley Orthopedic Institute

New Patient Form

NAME:_____ TODAY'S DATE:_____

AGE_____ DATE OF BIRTH_____ HEIGHT_____ WEIGHT_____

ARE YOU RIGHT OR LEFT HANDED:_____ OCCUPATION:_____

CHIEF COMPLAINT (please circle one): SHOULDER ELBOW WRIST HAND
HIP KNEE ANKLE FOOT
RIGHT LEFT BOTH

REASON FOR VISIT: _____

_____

WHEN DID YOUR SYMPTOMS START? _____

DID YOU HAVE A SPECIFIC INJURY? (please circle) YES NO

IF YES PLEASE DESCRIBE: _____

WAS THE INJURY WORK RELATED? (Please circle) YES NO

HOW SEVERE IS YOUR PAIN? (On a scale of 0-10 with 10 being the worst pain ever felt) _____

TYPE OF PAIN (circle all that apply): DULL SHARP THROBBING ACHY STABBING SHOOTING

OTHER_____

DOES YOUR PAIN AWAKEN YOU FROM SLEEP? (please circle) YES NO

DO YOU GET PAIN WITH (circle all that apply):

OVERHEAD ACTIVITIES THROWING LIFTING CARRYING REACHING SQUATTING
WEIGHT BEARING ACTIVITIES AT REST CLIMBING STAIRS
OTHER_____

WHICH OF THE FOLLOWING SYMPTOMS IS THE MOST BOTHERSOME(please circle one):

PAIN WEAKNESS STIFFNESS INSTABILITY

DO YOU GET ANY OF THE FOLLOWING (circle all that apply):

WEAKNESS INSTABILITY SWELLING CLICKING NUMBNESS NIGHT PAIN
STIFFNES LOSS OF RANGE OF MOTION CATCHING TINGLING NECK PAIN

DURATION OF SYMPTOMS (please circle one): INTERMITTENT CONSTANT

WHAT MODIFIES OR DECREASES THE SYMPTOMS (please circle all that apply)

REST HEAT COLD ELEVATION MEDS PT OTHER: _____ _____

OTHER SYMPTOMS: _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM (circle all that apply):

X-RAYS MRI EMG PHYSICAL THERAPY ICE HEAT
MEDICATIONS INJECTIONS SURGERY OTHER _____

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PAST MEDICAL HISTORY: (Please circle Yes or No for the following medical conditions)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Stomach Problems	Yes	No
Latex Allergy	Yes	No	Thyroid Problems	Yes	No	Sleep Apnea	Yes	No
Hepatitis	Yes	No	Blood Clots	Yes	No	Other _____		

PAST SURGERIES AND APPROXIMATE DATES:

_____

_____

_____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____ _____ _____

_____ _____ _____

FAMILY HISTORY: (any medical problems in your blood relatives)

Mother:_____ Father: _____ Siblings: _____

SOCIAL HISTORY: Maritial Status (circle one) Single Married Separated Divorced Widowed

Tobacco Use: Never Currently Smoke, How many per day? _____ Quit/When: _____

Alcohol Use: Never Rarely Moderate Daily (how much):_____

REVIEW OF SYSTEMS: Do you have trouble with any of the following? (circle all that apply)

Headache	Eyesight	Hearing	Swallowing
Chest Pain	Shortness of Breath	Diarrhea	Constipation
Poor Circulation	Blood in Stool	Ulcers	Painful Urination
Leg Swelling	Night Sweats	Weight Loss	Balance
Rashes			

Patient Signature: _____ Date: _____

Physician Signature:_____ Date:_____