

NEW PATIENT SELF ASSESSMENT



Reason for Visit _____

Duration _____

Problem is the result of a(n): Car Accident Work Accident Accident Other Date of Injury _____

Current limitations: _____

Do you use a: Cane Crutches Walker Wheelchair Pain 0 – 10 (10 Severe) _____

How would you describe your pain and how often do you have it? Sharp Dull Aching Burning Shooting

Daily Nightly Constant Intermittent _____

Previous treatments including surgery: _____

PAST HISTORY

Significant Medical Conditions: _____

Previous Surgical History: _____

Are you under the care of a Cardiologist: Yes No Name: _____

Have you ever had problems with anesthesia in the past? Yes No If yes, explain: _____

Do you suffer from sleep apnea? Yes No

FAMILY HISTORY

Gout: Yes No Rheumatoid Arthritis: Yes No Cardiac Issues: Yes No

Who? _____

Other significant orthopedic problems: Yes No Who? _____

SOCIAL HISTORY

Occupation: _____ Currently working? Yes No

Marital Status: Single Married Divorced Widowed

Do you have children: Yes No How many? _____

Do you live alone Yes No Who lives with you? _____

Is someone available to help you at home if you had surgery? Yes No

Do you exercise regularly? Yes No

What type of exercise do you do? _____ How often? _____

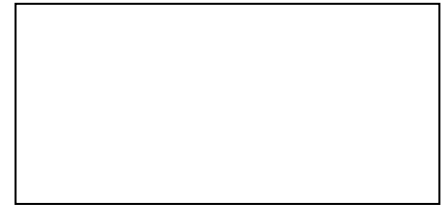
Alcohol Use: _____ Drinks per night _____ Drinks per week Monthly Other Drugs _____

Have you ever felt unsafe or been afraid of anyone? Yes No

Have you lost or gained more than 10 lbs in the last 3 months without trying or wanting to lose weight? Yes No

REVIEW OF SYSTEMS CHECKLIST

Do you CURRENTLY have any of the following? (IF YES, CHECK APPROPRIATE BOXES)



General –

- Weight gain >10 pounds
- Weight loss >10 pounds
- Fatigue
- Fever or chills

Skin –

- Rashes
- Lumps
- Itching
- Skin color changes
- Hair and nail changes

Head –

- Headache
- Head injury
- Neck pain

Eyes –

- Vision loss/changes
- Eye redness
- Blurry or double vision
- Glaucoma
- Cataracts

Ears –

- Decreased hearing
- Earache
- Drainage

Nose –

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nose bleeds
- Sinus pain

Throat –

- Sore tongue
- Dry mouth
- Sore throat
- Hoarseness
- Thrush
- Non-healing sores

Neck –

- Swollen glands
- Neck pain
- Neck stiffness

Respiratory –

- Chronic cough
- Coughing up blood
- Shortness of breath
- Wheezing

Cardiovascular –

- Chest pain or discomfort
- Leg pain with walking
- Palpitations
- Shortness of breath with activity
- Difficulty breathing lying down
- Leg swelling
- Sudden awakening from sleep with shortness of breath

Gastrointestinal –

- Swallowing difficulties
- Abdominal pain
- Ulcers or gastritis
- Hepatitis
- Rectal bleeding

Genitourinary –

- Menstrual irregularities
- Difficulty starting/stopping urinary stream
- Painful urination
- Increased frequency
- Blood in urine
- Loss of bladder control

Musculoskeletal –

- Decreased range of motion
- Joint pain
- Joint redness
- Joint swelling
- Joint stiffness
- Muscle weakness
- Muscle aches/pains

Neurological –

- Dizziness/vertigo
- Fainting
- Seizures
- Numbness/tingling

Hematologic –

- Easy bruising
- Prolonged bleeding

Endocrine –

- Diabetes
- Increased urination
- Increased thirst

Psychiatric –

- Anxiety
- Depression
- Suicidal thoughts
- Hallucinations

All systems were reviewed and are negative.

I believe that my answers are correct.

Patient's Signature

Date

Time

I have reviewed the above information with the patient.

Physician's Name (Print)

Physician's Signature

Date

Time