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.	**I have reviewed the above information with the patient.**
_____	_____
Patient's Signature Date Time	**Physician's Name (Print)**
	_____
	Physician's Signature Date Time