UT★Physicians
ORTHOPAEDICS

NEW PATIENT HISTORY

Patient Name _____ **Age** _____ **Date** _____

Occupation _____ ☐ **Male** ☐ **Female**

Who may we thank for your referral: _____

Current Problem: _____ **Date problem began:** _____

Are you experiencing any of the following: (check)

☐ **Pain** ☐ **Swelling** ☐ **Redness** ☐ **Limited Motion** ☐ **Muscle Weakness** ☐ **Loss of Muscle** ☐ **Cramps**

☐ **Popping** ☐ **Locking/Catch** ☐ **Stiffness** ☐ **Numbness** ☐ **Tingling** ☐ **Mass** ☐ **Deformity**

Have you been treated for this problem before? ☐ **No** ☐ **Yes** **What kind of treatment:** ☐ **Medication** ☐ **Injection**

☐ **Splint/Brace** ☐ **Therapy** ☐ **Surgery** ☐ **X-rays** ☐ **MRI** ☐ **Nerve Test** ☐ **Other:** _____

Are you Allergic to any medications? ☐ **No** ☐ **Yes** **List:** _____

Have you ever had an adverse reaction to a blood transfusion? ☐ No ☐ Yes

Do you have an allergy to tape or adhesives? ☐ No ☐ Yes Have you ever had problems with anesthesia? ☐ No ☐ Yes

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes Surgeries (Date): _____

CURRENT MEDICATIONS

Please list all medication you are currently taking, including aspirin, herbal remedies, and any over-the-counter medications, (If you are taking more than 6 medications, continue on reverse side or seperate sheet)

Medication	Strength	How Often Taken

Have you ever used steroid medications (cortisone, prednisone, etc.) No [ ] Yes [ ]

HABITS

Tobacco Use ☐ No ☐ Yes Type and Amount per Day _____

Alcohol Use ☐ No ☐ Yes Type and Frequency _____

Drug Use ☐ No ☐ Yes Type and Frequency _____

Caffeine Use ☐ No ☐ Yes Type and Frequency _____

Exercise ☐ No ☐ Yes Type and Frequency _____

HEALTH

Do you have, or have you ever had, any of the following? Check all that apply:

☐ AIDS/HIV+
☐ Arthritis, Bursitis
☐ Asthma
☐ Back Pain
☐ Blood Clots
☐ Cancer
  ☐ Benign _____
  ☐ Malignant _____
☐ Depression
☐ Diabetes (Sugar)
  ☐ Insulin
  ☐ Oral Medications
  ☐ Regulated by Diet
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Gallbladder Trouble
☐ Glaucoma
☐ Gout
☐ Hay Fever
☐ Heart attack
☐ Heart Disease
☐ Hemorrhoids
☐ Hepatitis or Jaundice
☐ Hernia
☐ Hypertension / High Blood Pressure
☐ Infection
  ☐ Staph _____
  ☐ MRSA _____
  ☐ Other _____
☐ Kidney Disease
☐ Kidney Stone
☐ Leukemia
☐ Loss of any part of arm/leg
☐ Lung Disease
☐ Osteoporosis
☐ Palsy
☐ Pancreatitis
☐ Pneumonia
☐ Psoriasis
☐ Psychiatric treatment
☐ Pulmonary Embolism
☐ Rheumatoid Fever
☐ Scarlet Fever
☐ Strokes
☐ TB
☐ Thyroid Disease
☐ T.I.A.
☐ Tumor / Growth / Cyst
☐ Ulcer - Gastric
☐ Ulcer - Peptic
☐ Venereal Disease
☐
☐
☐
☐ Other _____
☐ _____
☐ _____

Females Only

Are you pregnant? ☐ No ☐ Yes

Have you had a baby within the last month? ☐ No ☐ Yes

Are you currently taking birth control pills? ☐ No ☐ Yes How long? _____

Are you on hormone therapy? ☐ No ☐ Yes Name: _____ Dose: _____

Who is your primary care physician: _____ **Phone:** _____

REVIEW OF SYSTEMS: (Check all that you have experienced recently). ALL QUESTIONS MUST BE ANSWERED

General

No	Yes	
☐	☐	Weight loss
☐	☐	Weight gain
☐	☐	Poor appetite
☐	☐	Chills
☐	☐	Fever
☐	☐	Night Sweats

Skin

No	Yes	
☐	☐	Rash
☐	☐	Hives
☐	☐	Lesions

Head/Eyes/Ears/Nose/Throat

No	Yes	
☐	☐	Hay fever
☐	☐	Postnasal drip
☐	☐	Hoarseness
☐	☐	Visual problems
☐	☐	Nose bleeds
☐	☐	Neck stiffness/pain

Psychiatric

No	Yes	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Other _____

_____

Pulmonary

No	Yes	
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Coughing
☐	☐	Coughing up blood

Genitourinary

No	Yes	
☐	☐	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

No	Yes	
☐	☐	Indigestion
☐	☐	Gas
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Vomiting blood
☐	☐	Yellow skin
☐	☐	Abdominal pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Black stools
☐	☐	Rectal bleeding

Musculoskeletal

No	Yes	
☐	☐	Pain
☐	☐	Swelling
☐	☐	Redness
☐	☐	Limited motion
☐	☐	Weakness
☐	☐	Atrophy
☐	☐	Cramps
☐	☐	Popping
☐	☐	Locking/catching
☐	☐	Stiffness
☐	☐	Numbness
☐	☐	Tingling
☐	☐	Mass
☐	☐	Deformity

Lymphatics

No	Yes	
☐	☐	Lymph node swelling
☐	☐	Node tenderness

Endocrine

No	Yes	
☐	☐	Excessive urination
☐	☐	Excessive thirst
☐	☐	Excessive appetite
☐	☐	Hot intolerance
☐	☐	Cold intolerance
☐	☐	Easy bleeding

Cardiovascular

No	Yes	
☐	☐	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 one of the following? If so, indicate their relationship to you (e.g. Diabetes - maternal grandmother)

No	Yes		No	Yes		No	Yes		No	Yes	
☐	☐	Diabetes	☐	☐	Liver Trouble	☐	☐	Arthritis	☐	☐	Psychiatric Disease
☐	☐	Tuberculosis	☐	☐	High Blood Pressure	☐	☐	Cancer	☐	☐	Unusual Reaction to Anesthesia
☐	☐	Heart Trouble	☐	☐	Any Unusual Disease	☐	☐	Blood Disease	☐	☐	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: _____

_____

_____

_____ _____

Physician Signature **Date**