

New Patient Medical Information Questionnaire

****This is important information which your doctor needs to know. Please provide as much detail as possible****

Were you referred to this office? N Y If so, by whom? _____

Patient's Full Name _____ Female Male

Date of Birth ____/____/____ Age _____ Height ____/____ Weight _____ Marital Status S M D W

What is the main reason for this visit? _____

What body part is involved? Right Left Both _____

How long has this bothered you? _____

Please describe your symptoms by checking all boxes that apply:

Pain N Y Other Please describe _____

Please rate your discomfort by circling: None= 0 1 2 3 4 5 6 7 8 9 10 = Severe

Where is the pain and how far does it extend to? _____

What is the quality of the pain? sharp dull throbbing burning other _____

What is the duration of the pain? constant intermittent, off and on other _____

When do symptoms occur? all day and night in the morning only during the day only at night only

with activity Please describe the activity _____

What makes your symptoms better? _____

Please give examples _____

What makes your symptoms worse? _____

Please give examples _____

Are you taking any medication for this? N Y If so, what medicine and dosage? _____

Have you had any other treatment for this problem? N Y What? _____

Past & Present Illnesses or Injuries:

Do you have now or have you ever had:	No	Yes	Current	Past	Year	Please describe
CON: fever, recent weight loss, loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
EYES: vision disturbance, glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HENT: hearing, sinus or throat disorder, dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CVD: heart disorder, high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
RESP: asthma, lung disorder, pneumonia, TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
GI: ulcers, diarrhea, constipation, hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
GU: kidney, bladder, or bowel disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MS: stiff or painful joints, arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
IS: skin or breast disorder, rash, lumps, scars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
N: seizures, numbness, weakness, memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**** Please turnover and continue on the back side of this form. ****

Do you have now or have you ever had:	No	Yes	Current	Past	Year	Please describe
P: depression, mood or sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
E: thyroid disorder, diabetes, hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
H/L: bleeding, bruising, anemia, enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Have you ever had rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Have you had any previous fractures or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Have you ever had back or neck problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Have you ever had cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Do you use tobacco? If so, how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Do you use alcohol? If so, how often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Are you claustrophobic? N Y Please list: _____

Do you have any allergies? N Y Please list: _____

Are you allergic to any medications? N Y Please list: _____

Are you currently taking any medications? N Y Please list: _____

Are you currently working? N Y If no, how long have you been off work? _____

Have you had any Surgeries or Hospitalizations? N Y If so, please list here:

Reason _____ Date ____/____/____ Doctor _____

Reason _____ Date ____/____/____ Doctor _____

Reason _____ Date ____/____/____ Doctor _____

Have you ever had a reaction to anesthesia? N Y

Family History: Have any family members had any of the following disorders? If so, which relative?

Arthritis N Y _____ & Type, if known _____ Heart disease N Y _____

Muscle disease N Y _____ Diabetes N Y _____ High Blood Pressure N Y _____

Cancer N Y _____ Are your parents living? N Y If deceased, what was the cause of death and their age at death? _____

Accident Information

If your injury is the result of an accident, where did it happen? _____

How did the accident happen? _____

Date of Injury ____/____/____ Other details _____

Authorization and Consent to Medical Services and/or Treatment	
I hereby authorize the Doctor/Physician Assistant/Nurse Practitioner to provide medically necessary services, including x-rays, fracture treatment, casting, or procedures done in the office, which are determined to be in the best interest of the patient.	
Signature of Patient, or person authorized by law	Date ____/____/____
<i>relationship to patient</i>	

Reviewed for completeness by _____ MD signature _____ Date ____/____/____