

Name_____ Age_____ Date __/__/__

Date of Injury ____/____/____ Work Related ____Yes ____No

What is the problem our are being seen for today : _____

Severity_____ (How severe is the pain?)

Associated signs/symptoms_____

<u>Year</u>	<u>Operation/Illness</u>	<u>Year</u>	<u>Operation/Illness</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<u>Allergy</u>	<u>Reaction</u>

[illegible]

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New Patient Examination

5. Height _____ Weight _____

6. What conditions are you currently being treated for?

Condition	How long have you had this condition?
_____	_____
_____	_____
_____	_____
_____	_____

7. **Review of Systems.** Have you ever experienced:

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety or nervousness for which you've been treated	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscular pain in the legs or buttocks while walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Strokes or temporary lapse in memory	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart attack or chest pain during activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart rhythm disturbances	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart catheterization or stress testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent night time awakening due to shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath with mild exertion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Need to sleep propped up on 2 or more pillows	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear dentures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of peptic ulcers or intestinal bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary difficulties or loss of continence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent swelling of lower extremities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of unusual frequent infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive surgical bleeding, bruising or nose bleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there any possibility you are pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. Do you have any known **family history** of:

Difficulties with anesthesia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart attack or angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding tendencies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis (TB)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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9. Do you use any special breathing equipment at home? ☐Yes ☐No
If yes Nebulizer Inhalers Oxygen Breathing treatments
10. Do you have a history of TB? ☐Yes ☐No
Have you been exposed to TB? ☐Yes ☐No
11. Recent History of:
Productive Cough Lethargy/Weakness Night Sweats Weight Loss
Coughing up blood Fever Loss of Appetite
12. Have you ever had difficulties with anesthesia? Yes No
13. Do you use tobacco? ☐No ☐Yes Type: ☐Pipe ☐Cigar ☐Chew
☐Cigarettes: _____ packs per day for _____ years
14. Do you drink alcohol? ☐Yes ☐No
If Yes: How much? _____ How often? _____
Date of last drink: _____
15. Do you use street/recreational drugs? ☐ No ☐Yes ☐In a recovery program
Date last used: _____
16. Dietary/Nutritional
Do you have any special diet, food or cultural preferences/requirements?
☐Regular ☐Kosher ☐Low Cholesterol ☐Vegetarian
☐Diabetic (please identify calorie count) _____
Have you had a recent weight change: ☐Yes ☐No
If no answered yes, was the change a: ☐Gain ☐Loss
How many pounds _____
- Do you have any difficulty with passing urine or stool? ☐Yes ☐No
Urinary catheter Constipation On Dialysis
Colostomy Ileostomy Urinary Tract Infections
17. Do you have any problems with your vision? ☐Yes ☐No
Vision aids used: ☐Glasses ☐Contact lens
18. Do you have any problems with your hearing? ☐Yes ☐No
Hearing aids used: _____

Form completed by _____ Date ____/____/____

If other than the patient, please identify the relationship _____