New Patient Inquiry

Date of first appointment: / / Time of appointment: Birthplace:

MONTH DA Y YEAR

Name: Birthdate: / /

LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: Age: Sex: ‰ F ‰ M

STREET APT#

 Telephone: Home ( )

CITY STATE ZIP Work ( )

MARITAL STATUS: ‰ Never Married ‰ Married ‰ Divorced ‰ Separated ‰ Widowed

Spouse/Significant Other: ‰ Alive/Age ‰ Deceased/Age Major Illnesses

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School Occupation Number of hours worked/average per week

Referred here by: (check one) ‰ Self ‰ Family ‰ Friend ‰ Doctor ‰ Other Health Professional

MEDICAL HISTORY

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram Date of last eye exam Date of last chest x–ray Date of last Tuberculosis Test Date of last bone densitometry

Constitutional

[ ]  Recent weight gain

amount

[ ]  Recent weight loss

amount

[ ]  Fatigue

[ ]  Weakness

[ ]  Fever

Eyes

[ ]  Pain

[ ]  Redness

[ ]  Loss of vision

[ ]  Double or blurred vision

[ ]  Dryness

[ ]  Feels like something in eye

[ ]  Itching eyes

Ears–Nose–Mouth–Throat

[ ]  Ringing in ears

[ ]  Loss of hearing

[ ]  Nosebleeds

[ ]  Loss of smell

[ ]  Dryness in nose

[ ]  Runny nose

[ ]  Sore tongue

[ ]  Bleeding gums

[ ]  Sores in mouth

[ ]  Loss of taste

[ ]  Dryness of mouth

[ ]  Frequent sore throats

[ ]  Hoarseness

[ ]  Difficulty in swallowing

Cardiovascular

[ ]  Pain in chest

[ ]  Irregular heart beat

[ ]  Sudden changes in heart beat

[ ]  High blood pressure

[ ]  Heart murmurs

Respiratory

[ ]  Shortness of breath

[ ]  Difficulty in breathing at night

[ ]  Swollen legs or feet

[ ]  Cough

[ ]  Coughing of blood

[ ]  Wheezing (asthma)

Gastrointestinal

[ ]  Nausea

[ ]  Vomiting of blood or coffee ground material

[ ]  Stomach pain relieved by food or milk

[ ]  Jaundice

[ ]  Increasing constipation

[ ]  Persistent diarrhea

[ ]  Blood in stools

[ ]  Black stools

[ ]  Heartburn

Genitourinary

[ ]  Difficult urination

[ ]  Pain or burning on urination

[ ]  Blood in urine

[ ]  Cloudy, “smoky” urine

[ ]  Pus in urine

[ ]  Discharge from penis/vagina

[ ]  Getting up at night to pass urine

[ ]  Vaginal dryness

[ ]  Rash/ulcers

[ ]  Sexual difficulties

[ ]  Prostate trouble

For Women Only:

Age when periods began: Periods regular? [ ]  Yes [ ]  No

How many days apart?

Date of last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last pap? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding after menopause? [ ]  Yes [ ]  No Number of pregnancies?

Number of miscarriages?

Musculoskeletal

[ ]  Morning stiffness

Lasting how long?

 Minutes Hours

[ ]  Joint pain

[ ]  Muscle weakness

[ ]  Muscle tenderness

[ ]  Joint swelling

List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

[ ]  Easy bruising

[ ]  Redness

[ ]  Rash

[ ]  Hives

[ ]  Sun sensitive (sun allergy)

[ ]  Tightness

[ ]  Nodules/bumps

[ ]  Hair loss

[ ]  Color changes of hands or feet in the cold

Neurological System

[ ]  Headaches

[ ]  Dizziness

[ ]  Fainting

[ ]  Muscle spasm

[ ]  Loss of consciousness

[ ]  Sensitivity or pain of hands and/or feet

[ ]  Memory loss

[ ]  Night sweats

Psychiatric

[ ]  Excessive worries

[ ]  Anxiety

[ ]  Easily losing temper

[ ]  Depression

[ ]  Agitation

[ ]  Difficulty falling asleep

[ ]  Difficulty staying asleep

Endocrine

[ ]  Excessive thirst

Hematologic/Lymphatic

[ ]  Swollen glands

[ ]  Tender glands

[ ]  Anemia

[ ]  Bleeding tendency

[ ]  Transfusion/when

Allergic/Immunologic

[ ]  Frequent sneezing

[ ]  Increased susceptibility to infection

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day?

Do you smoke? [ ]  Yes [ ]  No [ ]  Past – How long ago?

Do you drink alcohol? [ ]  Yes [ ]  No Number per week

Has anyone ever told you to cut down on your drinking?

[ ]  Yes [ ]  No

Do you use drugs for reasons that are not medical? [ ]  Yes [ ]  No

If yes, please list:

Do you exercise regularly? [ ]  Yes [ ]  No

Type

Amount per week

How many hours of sleep do you get at night?

Do you get enough sleep at night? [ ]  Yes [ ]  No

Do you wake up feeling rested? [ ]  Yes [ ]  No

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if “yes”)

[ ]  Cancer [ ]  Heart problems [ ]  Asthma

[ ]  Goiter [ ]  Leukemia [ ]  Stroke

[ ]  Cataracts [ ]  Diabetes [ ]  Epilepsy

[ ]  Nervous breakdown [ ]  Stomach ulcers [ ]  Rheumatic fever

[ ]  Bad headaches [ ]  Jaundice [ ]  Colitis

[ ]  Kidney disease [ ]  Pneumonia [ ]  Psoriasis

[ ]  Anemia [ ]  HIV/AIDS [ ]  High Blood Pressure

[ ]  Emphysema [ ]  Glaucoma [ ]  Tuberculosis

Other significant illness (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Operations

|  |  |  |
| --- | --- | --- |
| Type | Year | Reason |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |

Any previous fractures? [ ]  No [ ]  Yes Describe: Any other serious injuries? [ ]  No [ ]  Yes Describe:

FAMILY HISTORY:

|  |  |
| --- | --- |
| IF LIVINGAge Health | IF DECEASEDAge at Death Cause |
| Father |  |  |  |  |
| Mother |  |  |  |  |

Number of siblings Number living Number deceased

Number of children Number living Number deceased List ages of each Health of children:

Do you know of any blood relative who has or had: (check and give relationship)

[ ]  Cancer

[ ]  Leukemia

[ ]  Stroke

[ ]  Colitis

[ ]  Heart disease

[ ]  High blood pressure

[ ]  Bleeding tendency

[ ]  Alcoholism

[ ]  Rheumatic fever

[ ]  Epilepsy

[ ]  Asthma

[ ]  Psoriasis

[ ]  Tuberculosis

[ ]  Diabetes

[ ]  Goiter

MEDICATIONS

Drug allergies: [ ]  No [ ]  Yes To what?

Type of reaction:

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Drug | Dose (include strength & number of pills per day) | How long have you taken this medication | Please check: Helped?A Lot Some Not At All |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| 5. |  |  |  |  |  |
| 6. |  |  |  |  |  |
| 7. |  |  |  |  |  |
| 8. |  |  |  |  |  |
| 9. |  |  |  |  |  |
| 10. |  |  |  |  |  |

PAST MEDICATIONS Please review this list of “arthritis” medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. Record your comments in the spaces provided.

|  |  |  |  |
| --- | --- | --- | --- |
| Drug names/Dosage | Length of time | Please check: Helped?A Lot Some Not At All | Reactions |
| Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) |  |  |  |  |  |
| Check any you have taken in the past |
| Ansaid (flurbiprofen) |  |  |  |  |  |
| Arthrotec (diclofenac + misoprostil) |  |  |  |  |  |
| Aspirin (including coated aspirin) |  |  |  |  |  |
| Celebrex (celecoxib) |  |  |  |  |  |
| Clinoril (sulindac) Daypro (oxaprozin) |  |  |  |  |  |
| Disalcid (salsalate) |  |  |  |  |  |
| Dolobid (diflunisal) |  |  |  |  |  |
| Feldene (piroxicam) |  |  |  |  |  |
| Indocin (indomethacin) |  |  |  |  |  |
| Lodine (etodolac) |  |  |  |  |  |
| Meclomen (meclofenamate) |  |  |  |  |  |
| Motrin/Rufen (ibuprofen) |  |  |  |  |  |
| Nalfon (fenoprofen) |  |  |  |  |  |
| Naprosyn (naproxen) |  |  |  |  |  |
| Oruvail (ketoprofen) |  |  |  |  |  |
| Tolectin (tolmetin) |  |  |  |  |  |
| Trilisate (choline magnesium trisalicylate) |  |  |  |  |  |
| Vioxx (rofecoxib) |  |  |  |  |  |
| Voltaren (diclofenac) |  |  |  |  |  |
| Pain Relievers |
| Acetaminophen (Tylenol) |  |  |  |  |  |
| Codeine (Vicodin, Tylenol 3) |  |  |  |  |  |
| Propoxyphene (Darvon/Darvocet) |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Disease Modifying Antirheumatic Drugs (DMARDS) |
| Auranofin, gold pills (Ridaura) |  |  |  |  |  |
| Gold shots (Myochrysine or Solganol) |  |  |  |  |  |
| Hydroxychloroquine (Plaquenil) |  |  |  |  |  |
| Penicillamine (Cuprimine or Depen) |  |  |  |  |  |
| Methotrexate (Rheumatrex) |  |  |  |  |  |
| Azathioprine (Imuran) |  |  |  |  |  |
| Sulfasalazine (Azulfidine) |  |  |  |  |  |
| Quinacrine (Atabrine) |  |  |  |  |  |
| Cyclophosphamide (Cytoxan) |  |  |  |  |  |
| Cyclosporine A (Sandimmune or Neoral) |  |  |  |  |  |
| Etanercept (Enbrel) |  |  |  |  |  |
| Infliximab (Remicade) |  |  |  |  |  |
| Prosorba Column |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Osteoporosis Medications |
| Estrogen (Premarin, etc.) |  |  |  |  |  |
| Alendronate (Fosamax) |  |  |  |  |  |
| Etidronate (Didronel) |  |  |  |  |  |
| Raloxifene (Evista) |  |  |  |  |  |
| Fluoride |  |  |  |  |  |
| Calcitonin injection or nasal (Miacalcin, Calcimar) |  |  |  |  |  |
| Risedronate (Actonel) |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Gout Medications |
| Probenecid (Benemid) |  |  |  |  |  |
| Colchicine |  |  |  |  |  |
| Allopurinol (Zyloprim/Lopurin) |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Others |
| Tamoxifen (Nolvadex) |  |  |  |  |  |
| Tiludronate (Skelid) |  |  |  |  |  |
| Cortisone/Prednisone |  |  |  |  |  |
| Hyalgan/Synvisc injections |  |  |  |  |  |
| Herbal or Nutritional Supplements |  |  |  |  |  |
| Please list supplements: |
|  |
|  |

Have you participated in any clinical trials for new medications? [ ]  Yes [ ]  No

 If yes, list:

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? [ ]  Yes [ ]  No If yes, how many?

How many people in household? Relationship and age of each

Who does most of the housework? Who does most of the shopping? Who does most of the yard work?

On the scale below, check which best describes your situation; Most of the time, I function…

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| VERY | POORLY | OK | WELL | VERY |
| POORLY |  |  |  | WELL |

Because of health problems, do you have difficulty:

(Please check the appropriate response for each question.)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Usually | Sometimes | No |
| Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.) |  |  |  |
| Walking?  |  |  |  |
| Climbing stairs |  |  |  |
| Descending stairs |  |  |  |
| Sitting down |  |  |  |
| Getting up from chair |  |  |  |
| Touching your feet while seated |  |  |  |
| Reaching behind your back |  |  |  |
| Reaching behind your head?  |  |  |  |
| Dressing yourself?  |  |  |  |
| Going to sleep?  |  |  |  |
| Staying asleep due to pain?  |  |  |  |
| Obtaining restful sleep?  |  |  |  |
| Bathing?  |  |  |  |
| Eating?  |  |  |  |
| Working?  |  |  |  |
| Getting along with family members?  |  |  |  |
| In your sexual relationship?  |  |  |  |
| Engaging in leisure time activities?  |  |  |  |
| With morning stiffness?  |  |  |  |
| Do you use a [ ]  cane, [ ]  crutches, as [ ]  walker or a [ ]  wheelchair?  |  |  |  |

What is the hardest thing for you to do?

|  |  |
| --- | --- |
| Are you receiving disability?  | Yes [ ]  No [ ]  |
| Are you applying for disability? |  Yes [ ]  No [ ]  |
| Do you have a medically related lawsuit pending? | Yes [ ]  No [ ]  |