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 LIVING  Age Health | | | IF DECEASED  Age 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 |