

LONGVIEW ORTHOPEDIC CLINIC NEW PATIENT INFORMATION
PLEASE TAKE JUST A FEW MINUTES TO TELL US ABOUT YOURSELF

History of Present Illness

What is the reason for your visit today _____

How long have you had this injury or illness _____

On a scale of 1 -10 how would you rate your pain _____

Where is the location of your pain or injury _____

Is there anything that makes the pain better or worse _____

What symptoms are you experiencing associated with this problem, if any

What medications, if any, are you taking for this problem _____

Please indicate if you are *currently* being treated for any of these conditions:

<input type="checkbox"/>	Fever/weight loss	<input type="checkbox"/>	Recent changes in your vision
<input type="checkbox"/>	Difficulty hearing	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Stomach problems, ulcers, reflux	<input type="checkbox"/>	Difficulty urinating or painful urination
<input type="checkbox"/>	Muscle aches, weakness	<input type="checkbox"/>	Loss of sensation, numbness or tingling
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heat/Cold intolerance.
<input type="checkbox"/>	Anemia or chronic infections	<input type="checkbox"/>	Allergies

Do you have *history* of any of the following conditions? Please check all that apply

<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Blood/bleeding disorders
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	HIV
<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Other
<input type="checkbox"/>	Peptic ulcer disease	<input type="checkbox"/>	

Do you have a *family history* of any of the following conditions? Please check all that apply

<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Blood/bleeding disorders
<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Gout
<input type="checkbox"/>	Other	<input type="checkbox"/>	

Please list your past surgical history; type of surgery, date of surgery

Do you Smoke? Yes or No How much _____
 Do you consume alcohol? Yes or No How often _____

Please list all medications you're currently taking

Medication	Dosage

Do you have any allergies to medications? Please list

Patient/Legal Guardian Signature _____ Date _____

Physician signature _____ Date reviewed _____