

LONGVIEW ORTHOPAEDIC 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:***

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

***Do YOU have HISTORY of any of the following conditions? Please check all that apply:***

Heart disease	High blood pressure
Vascular disease	Diabetes
Cancer	Blood / bleeding disorders
Hepatitis	HIV
Blood Clots	Rheumatoid Arthritis
Gout	Other
Peptic ulcer disease	

**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:**

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**Do you smoke? Yes or No How much \_\_\_\_\_**

**Do you consume alcohol? Yes or No How much \_\_\_\_\_**

**Please list all medications you're currently taking:**

Medication	Dosage

**Do you have any allergies to medications? Please list:**

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**Patient / Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_**

**Physician Signature \_\_\_\_\_ Date reviewed \_\_\_\_\_**