

# NEW PATIENT MEDICAL INFORMATION

## New Mexico Orthopaedics

Acct # \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Dominate Hand:  Right  Left Height \_\_\_\_\_ Weight \_\_\_\_\_

**Date of Injury** \_\_\_\_\_  On-The-Job Injury  Auto Accident  Sports Injury  Other \_\_\_\_\_

Is there (or will there be) an attorney involved with this problem? Yes  No

**Reason for Visit** (Describe problem/injury/symptoms) (Right or Left side?) \_\_\_\_\_

### Previous Treatment for this Problem

(If none, skip to next section)

Physicians/Providers Seen: \_\_\_\_\_

Arthrogram Date \_\_\_\_\_ Facility \_\_\_\_\_

Bone Scan Date \_\_\_\_\_ Facility \_\_\_\_\_

Casting/Splinting  
Date \_\_\_\_\_ Facility \_\_\_\_\_

Chiropractic/Acupuncture  
Date \_\_\_\_\_ Facility \_\_\_\_\_

EMG/Nerve Study  
Date \_\_\_\_\_ Facility \_\_\_\_\_

Injection Date \_\_\_\_\_ Facility \_\_\_\_\_

MRI Date \_\_\_\_\_ Facility \_\_\_\_\_

Physical Therapy  
Date \_\_\_\_\_ Facility \_\_\_\_\_

Vascular Studies  
Date \_\_\_\_\_ Facility \_\_\_\_\_

X-Rays Date \_\_\_\_\_ Facility \_\_\_\_\_

Other Date \_\_\_\_\_ Explain \_\_\_\_\_

### Relieving Factors:

Makes the problem/pain better?

- |  |   |
|--|---|
| <input type="checkbox"/> Acetaminophen/Tylenol       | <input type="checkbox"/> Muscle Relaxants             |
| <input type="checkbox"/> Anti-Inflammatory/Ibuprofen | <input type="checkbox"/> Prescription Pain Medication |
| <input type="checkbox"/> Aspirin                     | <input type="checkbox"/> Rest                         |
| <input type="checkbox"/> Physical Therapy            | <input type="checkbox"/> Sling                        |
| <input type="checkbox"/> Crutches                    | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Elastic Wrap Compression    | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Heat                        | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Ice                         | <input type="checkbox"/> Other _____                  |

### Aggravating Factors:

Makes the problem/pain worse?

- |  |   |
|--|---|
| <input type="checkbox"/> Bending         | <input type="checkbox"/> Movement of Area |
| <input type="checkbox"/> Deep Breath     | <input type="checkbox"/> Walking          |
| <input type="checkbox"/> Direct Pressure | <input type="checkbox"/> Weight Bearing   |
| <input type="checkbox"/> Exercise        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Grasping        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Lifting         | <input type="checkbox"/> Other _____      |

### Type of Pain

- |                                  |                                   |   |
|----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Aching  | <input type="checkbox"/> Numbness | <input type="checkbox"/> Pins & Needles |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Severe         |

**Describe the severity of the pain:** 0=None / 10=Worst

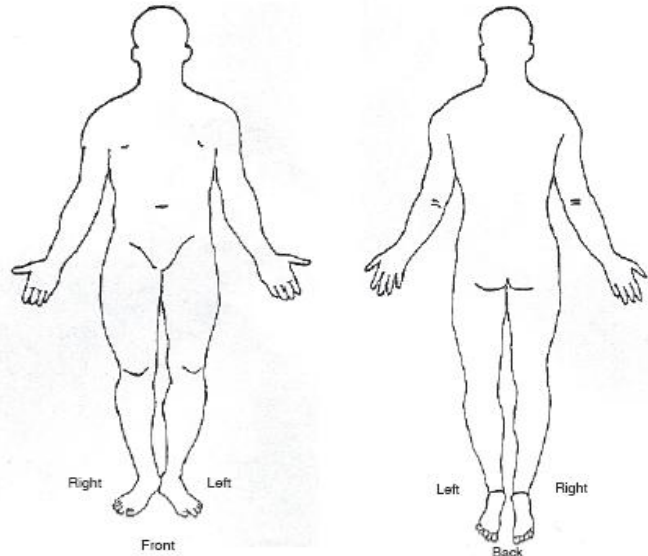
0 1 2 3 4 5 6 7 8 9 10

### Where are your symptoms now?

Mark the location of your pain on the picture below.

Place an **X** over the area of your pain.

Use an arrow → to show which direction your pain radiates.



### Women Only:

Is there a possibility you may be pregnant?  Yes  No

Are you postmenopausal?  Yes  No

Do you take estrogen?  Yes  No

Have you had bone density testing?  Yes  No

When? \_\_\_\_\_ Where? \_\_\_\_\_

Have you had a complete hysterectomy?

Yes (Age at time of procedure: \_\_\_\_\_)  No

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Anesthesiologist Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Medical History/ROS

Check & explain if you have had problems with:

- |  |  |
|--|--|
| <input type="checkbox"/> Anemia                                      | <input type="checkbox"/> Liver Disease _____     |
| <input type="checkbox"/> Anesthesia Complications                    | <input type="checkbox"/> Osteoarthritis          |
| <input type="checkbox"/> Anxiety                                     | <input type="checkbox"/> Paralysis/Numbness      |
| <input type="checkbox"/> Asthma/Breathing Problems                   | <input type="checkbox"/> Pneumonia               |
| <input type="checkbox"/> Bladder/Urinary system                      | <input type="checkbox"/> Rheumatoid Arthritis    |
| <input type="checkbox"/> Bleeding                                    | <input type="checkbox"/> Recent Weight Loss/Gain |
| <input type="checkbox"/> Blood Clots/Phlebitis                       | <input type="checkbox"/> Strokes (TIA)           |
| <input type="checkbox"/> Cancer _____                                |  |
| <input type="checkbox"/> Depression                                  | <input type="checkbox"/> Surgical Complications  |
| <input type="checkbox"/> Diabetes                                    | _____  |
| <input type="checkbox"/> Digestive System                            | _____  |
| <input type="checkbox"/> Ear/Nose/Throat                             | _____  |
| <input type="checkbox"/> Eyes  | _____  |
| <input type="checkbox"/> Fever, Chills, Night Sweats                 | <input type="checkbox"/> Ulcers/Stomach          |
| <input type="checkbox"/> Gout  | <input type="checkbox"/> Thyroid Disease _____   |
| <input type="checkbox"/> Headaches                                   | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Heart Disease/Heart Attack/Chest Pain _____ |  |
| <input type="checkbox"/> Hepatitis                                   |  |
| <input type="checkbox"/> Hiatal Hernia/Esophageal reflux             |  |
| <input type="checkbox"/> High Blood Pressure                         | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> High Cholesterol                            | _____  |
| <input type="checkbox"/> Hip or Spinal Fractures                     | _____  |
| <input type="checkbox"/> Joint Pain/Swelling                         | _____  |
| <input type="checkbox"/> Kidney Disease _____                        |  |

## Family History

Check family members who have been diagnosed with any of the following:

Relationship

- |   |       |
|---|-------|
| <input type="checkbox"/> Asthma/Breathing Problems                  | _____ |
| <input type="checkbox"/> Anesthesia/Surgical Complications          | _____ |
| <input type="checkbox"/> Bleeding                                   | _____ |
| <input type="checkbox"/> Blood Clots/Phlebitis                      | _____ |
| <input type="checkbox"/> Cancer                                     | _____ |
| <input type="checkbox"/> COPD Chronic Obstructive Pulmonary Disease | _____ |
| <input type="checkbox"/> Diabetes                                   | _____ |
| <input type="checkbox"/> Gout                                       | _____ |
| <input type="checkbox"/> Heart Disease/Heart Attack/Chest Pain      | _____ |
| <input type="checkbox"/> Hepatitis/Liver Disease                    | _____ |
| <input type="checkbox"/> High Blood Pressure                        | _____ |
| <input type="checkbox"/> High Cholesterol                           | _____ |
| <input type="checkbox"/> Osteoarthritis                             | _____ |
| <input type="checkbox"/> Rheumatoid Arthritis                       | _____ |
| <input type="checkbox"/> Strokes/Transient Ischemic Attacks (TIA)   | _____ |
| <input type="checkbox"/> Thyroid Disease                            | _____ |
| <input type="checkbox"/> Other/Explain _____                        | _____ |

## Past Surgical History

Check if you have had any of the following surgeries. (Indicate side by using R = Right /L = Left)

- |  |
|--|
| <input type="checkbox"/> <b>Ankle</b> Side: _____ Type: _____ Date _____                 |
| <input type="checkbox"/> <b>Arm</b> Side: _____ Type: _____ Date _____                   |
| <input type="checkbox"/> <b>Foot</b> Side: _____ Type: _____ Date _____                  |
| <input type="checkbox"/> <b>Hand</b> Side: _____ Type: _____ Date _____                  |
| <input type="checkbox"/> <b>Hip</b> Side: _____ Type: _____ Date _____                   |
| <input type="checkbox"/> <b>Knee</b> Side: _____ Type: _____ Date _____                  |
| <input type="checkbox"/> <b>Leg</b> Side: _____ Type: _____ Date _____                   |
| <input type="checkbox"/> <b>Shoulder</b><br>Side: _____ Type: _____ Date _____           |
| <input type="checkbox"/> <b>Wrist</b> Side: _____ Type: _____ Date _____                 |
| <input type="checkbox"/> <b>Spine Surgery</b> Type: _____ Date _____                     |
| <input type="checkbox"/> <b>Abdominal Surgery</b> _____                                  |
| <input type="checkbox"/> <b>Cardiac Surgery</b> _____                                    |
| <input type="checkbox"/> <b>Neurologic Surgery</b> _____                                 |
| <input type="checkbox"/> <b>Pacemaker Implantation Surgery</b><br>Type: _____ Date _____ |
| <input type="checkbox"/> <b>Thoracic Surgery</b> _____                                   |
| <input type="checkbox"/> <b>Other/Explain</b> _____                                      |
| <input type="checkbox"/> <b>Other/Explain</b> _____                                      |

## Social History

- Single  Married  Divorced  Widowed

Age(s) of child(ren): \_\_\_\_\_

- Exercise/Sports:**  Cycling  Gym Activities  
 Running  Swimming  Team Sports  Walking  
 Other \_\_\_\_\_; \_\_\_\_\_ times per week

**Do you use any of the following Tobacco products:**

- None  Cigarettes  Cigars  Smokeless Tobacco  
 Tobacco Use for \_\_\_\_\_ years Packs per day \_\_\_\_\_  
 Quit Tobacco (when) \_\_\_\_\_

**Do you drink alcohol?**  Yes  No

- Less than 12 drinks per year  
 Light (1-13 drinks per month)  
 Moderate (14-30 drinks per month)  
 Heavy (more than two drinks per day)

**Do you have a history of recreational drug use?**

- Yes  No Type/Name of Drug \_\_\_\_\_

**Do you take Calcium supplements?**  Yes  No

**Did either of your parents have osteoporosis?**

- Yes  No  Unknown

**Have you lost an inch or more in height?**

- Yes  No  Unknown

**Have you ever had/taken?**

- Chemotherapy  Steroids  
 Fractured Bone (as an adult)  Thyroid Medications  
 Immunosuppressive Medications