

Name _____

Date _____

New Patient Information Form

Alpine Orthopaedic Medical Group

Please Answer As Completely As Possible

Who sent you to see the orthopaedic surgeon today? _____

Who is your family/primary care doctor? _____

How old are you? _____ Date of Birth: _____ Sex: Male Female

Are you: Right-handed? Or Left-handed ?

Date of injury (if any) _____

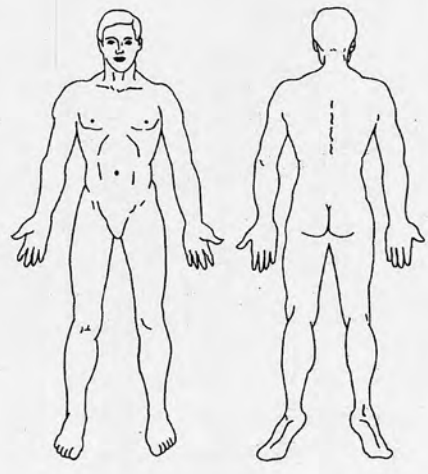
Why are you seeing the orthopaedic doctor today?

CONSTITUTIONAL FINDINGS (To be filled in by office staff):

HEIGHT: _____ WEIGHT: _____ PULSE: _____ BP: _____ TEMP: _____

Mark areas on the body diagram where you feel the described sensations using the appropriate symbols from the list below **ONLY** as it **RELATES** to the **PROBLEM** for which you are seeing the doctor **TODAY**. **NOT** everything that you feel.

Pain x x x x x x x x	Numbness - - - - - - - -	Pin & Needles o o o o o o o o
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Family History: Does or did any **blood relative** have any of the following conditions. Circle all that apply

NONE APPLY

Arthritis
Heart disease
High blood pressure
Diabetes

Cancer
Bleeding disorders
Mental illness
Alcoholism

Kidney disease
Other: _____

Review Of Systems: Do **YOU** currently have any of the following? Circle all that apply

NONE APPLY

CONSTITUTIONAL

Unexplained wt loss
Recent fevers or chills (past 1 or 2 weeks)
Recent night sweats

EYES

Glasses or contact lens
Recent change of vision

EAR, NOSE, MOUTH, THROAT

Difficulty swallowing
Hoarseness
Loss of hearing
Ear pain
Nosebleeds
Gum trouble

CARDIOVASCULAR

Heart or chest pain
Abnormal heartbeat

LUNG

Morning cough
Shortness of breath
Productive cough or sputum
Sleep Apnea
Use C-PAP machine

DIGESTIVE

Heartburn
Nausea or vomiting
Stomach pain or ulcers
Frequent diarrhea
Frequent constipation
Hemorrhoids

URINARY

Burning on urination
Difficulty starting urination
Incontinence
Urinate at night more than once
Unable to completely empty bladder

NEUROLOGICAL

Stroke
Seizures
Blackouts
Headaches/ migraines
Paralysis

MUCULOSKELETAL

Osteoporosis
Chronic joint pains
Chronic low back pain
Chronic neck pain

SKIN

Frequent rashes
Frequent itchiness
Easy bruising
Swollen ankles

PSYCHIATRIC

Depression
Nervous exhaustion
Anxiety
Paranoia
Obsessive compulsive disorder
Schizophrenia
Bulimia
Anorexia

ENDOCRINE

Diabetes
Take insulin

HEMATOLOGIC/LYMPHATIC

Anemia
Chronic swollen legs

ALLERGIC/IMMUNOLOGIC

Environmental allergens
Seasonal allergies
Asthma

HAVE YOU EVER HAD A BONE DENSITY SCAN (DEXA SCAN) ? YES NO

IF YES, WHEN WAS THE LAST TIME YOU HAD IT? _____

Patient's Signature _____

Date _____

Physician's Signature _____

Date _____