EVANGELISTA ORTHOPEDIC CLINIC

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NEW PATIENT HISTORY FORM

Name: _____ DOB_____ Age ____ HT_____ WT____

What are you seeing the doctor for today? _____

_____

Date of injury or onset of problem: _____ Affected side: Left Right

Have you had x-rays taken? Yes No If yes, where? _____

Have you had an MRI? Yes No If yes, where? _____

Previous Physician(s) you have seen for this problem (Please List)

Name	Address

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MEDICAL HISTORY Current and past medical problems (please check all applicable problems)

AIDS/HIV	COPD	Hepatitis B	Sleep Apnea
Anemia	Depression	Hepatitis C	Substance Abuse
Anxiety	Diabetes	High Blood Pressure	Thyroid Disorder
Arthritis	Fibromyalgia	High Cholesterol	Ulcer/Stomach Issues
Asthma	Gout	Kidney Trouble	Stroke
Bladder Issues	Heart Trouble	Neurological Disorders/Seizures	
Cancer	Hepatitis A	Phlebitis/Blood Clots	
Other (Please List)	_____	_____	_____

SURGICAL HISTORY NONE (Please enter previous procedures in the table below)

Surgical Procedure(s)	Month/Year

HOSPITALIZATION NONE (Please enter previous Hospitalizations in the table below)

Reason(s)/Procedure(s)	Month/Year

MEDICATIONS NONE

If you are taking medications, please list all **current** prescription & non-prescription medications, vitamins, and herbal products. INCLUDE even occasional use of aspirin or anti-inflammatory medication.

Name of Prescription	Dosage/Strength	Times Per Day

ALLERGIES NONE

If you have allergies, please INCLUDE allergies to medications and medical products (i.e. tape, latex, iodine).

Name of Medicine or Product	Description of Reaction

FAMILY HISTORY

Please list any major medical conditions and if they are deceased or alive.

Father: _____

Mother: _____

Siblings: _____

Has any blood relative younger than 50 ever had unusual bleeding tendencies? NO YES

If yes, Who and what is their age: _____

Have you or any blood relative younger than 50 ever had a serious reaction to anesthesia? NO YES

If yes, who and what is their age? _____

SOCIAL HISTORY

Do you now or have you ever smoked? NO YES

If yes, how long?_____ How often?_____ Year quit?_____

Do you drink alcohol? NO YES Average per week _____

Do you now or have you ever used drugs? NO YES

If yes, explain: _____