Arthritis and Joint Pain Center

New Patient Information	
Date:	

Last name	First name	Middle initial
Shipping Address	City State	Zip code
Billing Address (if different)	City State	Zip code
Email address	Preferred phone	Home/Cell

			Single Married Widowed Divorced Partnered
Date of birth	Age	Sex	Marital Status (circle)
Your Occupation			Employed by
Name of Spouse or Parent/ Guardian			Spouse or Parent/ Guardian Occupation
How did you hear about us?			

Physician/ Specific type	Name	Phone
Primary Care Physician (PCP)		

Height: _____ Feet _____Inches

Weight: _____Lbs.

PAIN DRAWING

Using the descriptive symbols, draw the location of your pain on the body outlines below.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
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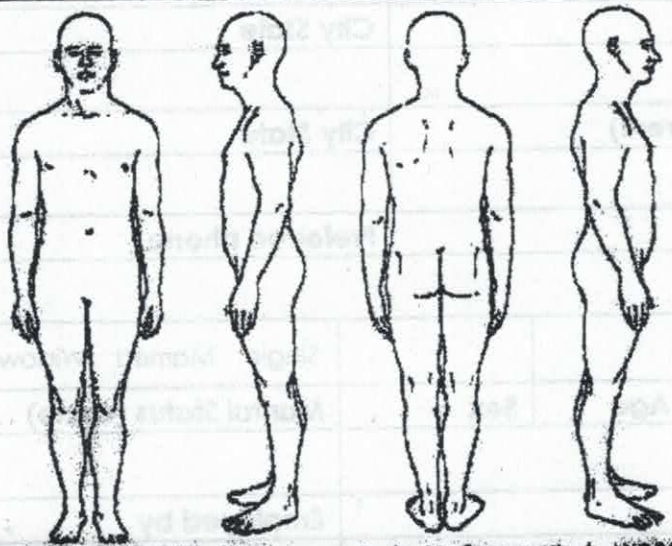

NO PAIN / Please make a slash through this line as to the level of your pain / WORST POSSIBLE PAIN

Social History

Please circle and answer

Do you Drink Caffeinated beverages? Yes/No Cups per day _____

Do you Smoke? Yes/No. Packs per day/week_____ How long?_____

Do you drink Alcohol? Yes/No Drinks a day/week_____

Do you use drugs for reasons that are not medical. Yes/No

If yes please list_____

_____

PAST MEDICAL HISTORY

Please Circle

Head Trauma	Cirrhosis	Seizures
Blindness	GERD	Migraines
Cataracts	Gallbladder Disease	Stroke/TIA
Glaucoma	Hepatitis	Bipolar Disorder
Wears Glasses/Contacts	Hiatal Hernia	Depression
Hearing Aids	Ulcer	Hallucinations/Delusions
Allergic Rhinitis	Hernia	Suicidal Ideation
Sinus Infection	Incontinence	Suicidal Attempts
Aneurysm	Other Kidney Disease	Hyperlipidemia
Angina	UTI(s)	Hyperthyroidism/Hypothyroidism
DVT	Arthritis	Type I Diabetes
HTN	Gout	Type II Diabetes
Heart Murmur	Muscular Injury	Anemia
Myocardial Infarction	Skeletal Injury	Cancer
Other Heart Disease	Psoriasis	HIV
Chronic Fatigue	Seizures	

FAMILY HISTORY

Relation	Condition	Relation	Condition
	Arthritis		Heart Disease
	Asthma		High Cholesterol
	Bleeding/Clotting Disorder		Hypertension
	COPD		Mental Illness
	Diabetes		Osteoporosis
	Heart Attack		Stroke
	Cancer		

Please Specify Types of Cancer: _____

Surgery History

Date	Procedure
	Aneurysm Repair
	Appendectomy
	Back Surgery
	Bariatric Surgery/Gastric Bypass
	Bilateral Tubal Ligation
	Breast Reduction/Mastectomy
	CABG
	Carotid
	Carpal Tunnel Release Surgery
	Cataract/Lens Surgery/LASIK
	C-Section
	Cholecystectomy/Bile Duct Surgery
	Hip Arthroplasty
	Hip Replacement
	Hysterectomy
	Inguinal Hernia Repair
	Knee Arthroplasty
	Nasal Surgery
	Pacemaker/Defibrillator
	Prostate Surgery
	Rotator Cuff Surgery
	Sinus Surgery
	Skin Cancer Excision
	Spinal Fusion
	TURP
	Tonsillectomy/Adenoidectomy
	Vasectomy

Comments:

Review of Symptoms

Please circle any you have had in the past year

Headache
Blurred Vision
Hearing Loss
Nosebleeds
Chest Pain
Shortness of Breath
Frequent Cough
Dizziness
Fainting
Vomiting
Constipation
Diarrhea
Indigestion
Blood in Stool
Abdomen Pain
Fatigue
Weight Gain/Loss
Palpitations
Loss of Appetite
Urine Infection
Blood in Urine
Other Urine Issues

Swollen Glands
Swollen Joints
Rash
Stress
Muscle Cramps
Numbness/Tingling
Wheezing
Coughing up Blood
Neck Pain
Back Pain
Joint Pain (Please List)

Medication

Name of Medication. Indicate if pills, drops ointment, etc.	Dose each time i.e., mg., drops, tsp., etc.	How many do you take at a time?	How often do you take this medication?	For what medical condition in this medication prescribed?

Allergies

Do you have an allergy to Sulfa? Yes _____ No _____

Medication or substance that caused this allergic reaction	What kind of reaction did you experience?	When did this reaction first occur?