

Towson Orthopaedic Associates

New Patient Evaluation

Form

PATIENT NO.:
DATE:

Physician seeing today: _____ Date: _____
 Name: _____ Age: _____ Birthdate: _____
 Patient SS #: _____ Address: _____
 Home #: _____ Cell #: _____ Work #: _____
 Employer: _____ Emergency contact/phone #: _____
 Referring Physician/phone #: _____ Primary Care Physician/phone #: _____
 Who referred you to the office today? _____

Current Medical Problem:

Why are you seeking a medical evaluation today? _____
 When did your symptoms begin? _____
 How would you describe your pain? (circle one) Sharp Dull Aching Stabbing Throbbing
 Do you have any of the following symptoms? (circle if yes) Locking Catching Painful Popping Instability Swelling
 What makes your pain worse? _____

 What makes your pain better? _____

 Does your pain radiate? _____
 What have you done for treatment? _____
 Have you seen any other physicians for this complaint? _____ Who? _____
 Have you had any tests to evaluate this problem? _____
 Have you ever had this problem before? _____

Past Medical History:

Have you ever been hospitalized? Yes No
 What were you hospitalized for? _____
 Please list any surgeries you have had: _____

Please list any drugs that you are now taking, prescription or not, that are not included in any previous question. Include Insulin and Coumadin if you are taking these drugs. If you have a long list, let us copy it.

DRUG	DOSE	HOW OFTEN	FOR HOW LONG	PRESCRIBED BY

Do you have any known drug allergies? Yes No
 What are you allergic to? _____
 List your current medical providers and their specialties: _____

General Medical History:

Please indicate if either the patient or family members have any of the following medical conditions. Indicate (p) for patient and (f) for family

- | | | | |
|------------------------|-------------------------------------|--------------------------------|---------------------------|
| _____ Asthma | _____ Single organ (kidney, testes) | _____ Osteoporosis | _____ Diabetes |
| _____ Anemia | _____ Heart Problem | _____ DVT | _____ Heat illness |
| _____ Seizures | _____ Kidney problem | _____ Gout | _____ Pulmonary embolism |
| _____ Migraines | _____ Concussions | _____ Gastrointestinal problem | _____ High blood pressure |
| _____ Bleeding problem | | _____ Hepatitis | |

Review of Symptoms:

Please check if you currently have a problem with any of the following:

- | | | |
|-----------------------|----------------------|-----------------------------------|
| _____ Headache | _____ Fever | _____ Pain With Urination |
| _____ Dizziness | _____ Weight Loss | _____ Fatigue |
| _____ Visual Problems | _____ Rashes | _____ Seizures |
| _____ Chest Pain | _____ Weight Gain | _____ History Of Stress Fractures |
| _____ Heart Murmur | _____ Joint Swelling | _____ Abdominal Pain |
| _____ Constipation | _____ Constipation | _____ Sun Sensitivity |
| _____ Diarrhea | | |

(Females)

Have you started menstruating? _____

When was your last menstrual period? _____

Is there any chance you are pregnant? Yes Possibly Can't be pregnant

Social History:

School Name: _____ Grade in School: _____

Who lives with you at home? _____

Do you exercise regularly? _____

What type of exercise or sport do you participate in? _____

Physical Examination:

Height: _____

Weight: _____

PHYSICIAN USE ONLY

Exam:

Tests ordered:

Disposition: