PREMIER ORTHOPAEDICS & SPORTS MEDICINE, P.C.

Spine and Trauma Institute / Advanced Center for Excellence in Spine Surgery
Administrative Office: 111 Galway Place, Suite 300, Teaneck, NJ 07666
Phone (201) 833-9500 • Fax (201) 862-0095

- Spinal Surgery
- American Board Of Orthopaedic Surgeons
- Sports Medicine
- Adult Reconstructive Surgery

NEW PATIENT HISTORY FORM

Patient Name: _____ Date: _____

1. Preferred Pharmacy (name and address): _____

2. Do you have any allergies? O YES O NO

Please list any allergies below:

Medications, Relevant Food, or "Seasonal"	**Reaction:** (anaphylaxis, rash, etc.)

3. Please list all medications you take on a regular basis: O NONE

Medications:

4. Do you have a personal history of any of the following medical conditions? O NONE

O Aneurysm Where: _____.	O Emphysema	O Kidney Disease
O Angina (Chest Pain)	O Epilepsy	O Kidney Stones
O Arthritis Type: _____.	O Heart Attack	O MRSA Infection
O Asthma	O Hepatitis Type: _____.	O Pacemaker
O Bone or Joint Infections	O HIV/AIDS	O Phlebitis (Blood Clots)
O Cancer Type: _____.	O High Cholesterol	O Pulmonary Embolism
O Chemotherapy/Radiation	O Hypertension	O Reaction to Anesthesia: _____.
O COPD	O Hyperthyroidism	O Seizures
O Congestive Heart Failure	O Hypothyroidism	O Stomach Ulcers
O Diabetes Type: _____ Last HA1C: _____.		O Stroke/TIA
		O Tuberculosis

5. Do you use Tobacco? O Daily O Occasionally O Former Smoker O Never

6. Race: O Caucasian O African American O Hispanic O Asian O Other: _____

7. Ethnicity: O Hispanic O Non-Hispanic O Other: _____.

8. Height: _____ Weight: _____

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Chief Complaint:

Dominant hand: ○Right hand ○Left Hand ○Ambidextrous

Description of the Symptoms

○Pain ○Numbness/Tingling ○Fracture ○Stiffness Other: _____.

Shoulder	○Right	○Left	**Pelvis**	○Right	○Left	**Neck**	○
Upper Arm	○Right	○Left	**Hip**	○Right	○Left	**Upper Back**	○
Elbow	○Right	○Left	**Thigh**	○Right	○Left	**Mid Back**	○
Forearm	○Right	○Left	**Knee**	○Right	○Left	**Low Back**	○
Wrist	○Right	○Left	**Lower Leg**	○Right	○Left	**Buttocks**	○
Hand	○Right	○Left	**Ankle**	○Right	○Left	**Tail Bone**	○
Thumb	○Right	○Left	**Foot**	○Right	○Left		
Index	○Right	○Left	**Great Toe**	○Right	○Left		
Middle	○Right	○Left	**2nd Digit**	○Right	○Left		
Ring	○Right	○Left	**3rd Digit**	○Right	○Left		
Little	○Right	○Left	**4th Digit**	○Right	○Left		
			5th Digit	○Right	○Left		

History of Present Illness

1. **Is your problem the result of an injury or accident?**

   ○No injury ○Injury ○Injury at Work ○Auto Accident ○Sport Injury ○Prior Surgery
   How long have the symptoms been present? (Ex: 2 days, 4 months) _____.
   Onset Date: (ex. 1/1/2013) _____.

2. **Are you represented by an attorney?** ○Yes ○No
   Attorney Name: _____.
   Will there be any legal actions with respect to this problem? ○Yes ○No

3. **Have you been seen in ER for this problem?** ○Yes ○No
   Treating ER: (ex. St. Luke's Health) _____
   Date: (ex. 1/1/2013) _____.

4. **Rate the pain (0 being no pain, 10 being so severe you consider going to the hospital):**
   ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Prior Treatment / Testing

Have you had any prior tests? ○None ○X-rays ○MRI ○CT Scan ○Nerve Test (EMG/NCV) ○Bone Scan

Have you had any prior treatment for this problem? ○Yes ○No

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Type of treatment **Status after treatment (Select only those that apply)**

Ice	O Improved	O Worsened	O Unchanged
Heat	O Improved	O Worsened	O Unchanged
Rest	O Improved	O Worsened	O Unchanged
NSAIDs	O Improved	O Worsened	O Unchanged
Muscle Relaxers	O Improved	O Worsened	O Unchanged
Chiropractor	O Improved	O Worsened	O Unchanged
Physical Therapy	O Improved	O Worsened	O Unchanged
Home Exercise Program	O Improved	O Worsened	O Unchanged
Surgery	O Improved	O Worsened	O Unchanged
Injections	O Improved	O Worsened	O Unchanged
Bracing	O Improved	O Worsened	O Unchanged
TENS unit	O Improved	O Worsened	O Unchanged

Other/Comments: _____.

Past Surgical History

Select all previous hospitalizations/surgeries: O None

O Aneurysm Brain Surgery	O Hysterectomy
O Aortic Bypass/Vascular Surgery	O LAP Band/ Gastric Bypass Surgery
O Appendectomy	O Lumpectomy
O Cataract (Eye) Surgery	O Mastectomy
O Cholecystectomy (Gallbladder)	O Malignancy/Cancer
O Heart Surgery	O Stents
O Hernia Repair	

Orthopedic	**Right**	**Left**
Arthroscopy: Knee	O	O
Arthroscopy: Shoulder	O	O
Carpal Tunnel Release	O	O
Rotator Cuff Repair	O	O
Total Hip Replacement	O	O
Total Knee Replacement	O	O
Total Shoulder Replacement	O	O
Spinal surgery	Level:	

Other Surgery: _____.

Review of Systems

Have experienced any of the following persistently in the last 6 months? O NONE FOR ALL

				None	Comments
1. GI	O Heartburn, Ulcers	O Nausea, Vomiting	O Blood in Stool	O	
2. ENDO	O Fever	O Heat/cold Intolerance	O Night Sweats	O	

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3. CON	OWeight loss	OLoss of Appetite	OFatigue	O	
4. EYE	OBlurred Vision	ODouble Vision	OVision Loss	O	
5. ENT	OHearing loss	OHoarseness	OTrouble Swallowing	O	
6. CV	OChest Pain	OPalpitations		O	
7. RS	OChronic Cough	OPneumonia	OShortness of Breath	O	
8. GU	OPainful Urination	OBlood in Urine	OKidney Problems	O	
9. SK	OFrequent Rashes	OSkin Ulcers	OLumps OPsoriasis	O	
10. NEU	OFrequent Falls	OLoss of Coordination	ONumbness	O	
	OChange in Bowel	OChange in Bladder	ODizziness	O	
11. PSY	ODepression/Anxiety	ODrug/Alcohol Abuse	OSleep Disorder	O	
12. HEM	OEasy Bleeding	OEasy Bruising	OAnemia	O	

Family History

Have any direct relatives had any of the following disorders? O NONE FOR ALL O UNKNOWN

Father	ONone	ODiabetes	OHeart Disease	OHypertension
	OBleeding Problems	OEpilepsy	OConnective Tissue	OMuscular Dystrophy
	OStroke	OOsteoporosis	ORheumatoid Arthritis	OCancer
	Comments (ex. Cancer type)			

Mother	ONone	ODiabetes	OHeart Disease	OHypertension
	OBleeding Problems	OEpilepsy	OConnective Tissue	OMuscular Dystrophy
	OStroke	OOsteoporosis	ORheumatoid Arthritis	OCancer
	Comments (ex. Cancer type)			

Sibling	ONone	ODiabetes	OHeart Disease	OHypertension
	OBleeding Problems	OEpilepsy	OConnective Tissue	OMuscular Dystrophy
	OStroke	OOsteoporosis	ORheumatoid Arthritis	OCancer
	Comments (ex. Cancer type)			

Social History

Do you drink alcohol? ODaily OOccasionally ONever OUnknown
Do you use street drugs? ODaily OOccasionally ONever OUnknown
Marital Status: OMarried OSingle ODivorced OWidowed ODomestic Partnership
Do you have any impairment? O Visual OHearing OSpeech OLearning OPhysical OLanguage/Cultural
Do you have any religious or culture customs that the provider should know about? OYes O No
Do you have a "Living Will" or Advance Directives? OYes ONo
Are you currently working? OYes ONo ORetired ODisabled If no, what date did you last work? _____.

Occupation: _____ **Employer:**_____ O **Student**