Huntington Health Physicians

NEW PATIENT FORM

PATIENT NAME: ______________________________ **DATE:** ________________

PLEASE CHECK BOXES NEXT TO SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE LAST 12 MONTHS.

✓	General
	weight loss _______lbs
	weight gain ______lbs
	fever
	night sweats
	fatigue

✓	Eyes
	pain
	redness
	dryness
	recent vision change

✓	Ear / Nose Mouth / Throat
	hearing loss
	nosebleed
	hoarse voice
	dry mouth
	mouth sores
	trouble swallowing

✓	Lungs
	shortness of breath
	trouble breathing at night
	dry cough
	cough with sputum

✓	Heart
	chest pain
	leg swelling
	palpitations

✓	Stomach/Intestines
	nausea
	vomiting
	heartburn
	constipation
	loose stools
	watery diarrhea
	blood in stools
	black stools

✓	Kidney / Urine / Bladder
	painful urination
	difficulty urinating
	frequent urination
	blood in urine
	vaginal dryness
	genital ulcers/rash

✓	Blood
	anemia
	easy bleeding
	previous blood clots

✓	Nervous System
	headaches
	numbness/tingling in hands/feet
	walking difficulty

✓	Skin
	rash
	nodules/bumps
	purplish/white color changes on tips of fingers
	redness with brief exposure to sun
	hair loss: ___years ___months

✓	Psychiatric
	depression; medications used: ________________________________
	anxiety/nervousness
	sleep problems

✓	For Women Only
age when periods began: ______	
	regular period, every _____ days
	irregular period, every _____ days
# of pregnancies ______	
# of miscarriages ______	
menopause at age ______	
Contraception: none IUD birth control pills tubal ligation other _______________________	

PREVIOUS TREATMENT / INJECTIONS FOR PAIN		
Previous Joint Injections	Joint _______________ month-year ________	
Joint _______________ month-year ________	Joint _______________ month-year ________	
Joint _______________ month-year ________	Joint _______________ month-year ________	
Previous Epidural Injections	cervical month-year ________	lumbar month-year ________
Previous Physical Therapy	acupuncture massage therapy	other alternative treatment _________

MEDICATION ALLERGIES If you have no medication allergies, please check here:	**Medication**	**Reaction**

PAST MEDICAL HISTORY – Please mark the conditions that you have.

	Osteoarthritis		Psoriasis/psoriatic arthritis		Hepatitis		Kidney disease
	Diabetes		Rheumatoid arthritis		Gout		Anemia
	Heart problems		High blood pressure		Asthma		High cholesterol
	Lupus or "SLE"		Cancer (type) _________________		Stroke		Hypothyroidism
	Osteoporosis		Stomach or peptic ulcer		Cataracts		Positive PPD

OTHER SIGNIFICANT ILLNESSES: ____

PAST SURGICAL HISTORY – Please mark the surgeries that you have had.

	Appendectomy		Oophorectomy (ovaries removed: left right both)
	Nasal septum surgery		Cesarean section (no. of times ______)
	Pacemaker implantation		Breast lumpectomy (left right both)
	Spinal epidural injections		Mastectomy (left right both)
	Vasectomy		Surgery for bone fractures (bones: ___________________)
	Colonoscopy (year ______)		Carpal tunnel release surgery (left right both)
	Gastric bypass surgery		Knee replacement (left right both)
	Hysterectomy		Hip replacement (left right both)
	Veins stripped		Cholecystectomy (gall bladder removal)
	Sinus surgery		Knee arthroscopic surgery (left right both)
	D & C		Shoulder rotator cuff surgery (left right both)
	Thyroid removed		Coronary artery bypass surgery or coronary artery stent
	Tonsillectomy		Ear PE (pressure equalizer) tubes
	Nose surgery (rhinoplasty)		Tummy tuck (abdominoplasty)

OTHER SURGERIES: ____

FAMILY HISTORY

Condition now or in the past	MOTHER	FATHER	BROTHERS	SISTERS	DAUGHTERS	SONS
Arthritis (indicate type to right)						
Cancer (indicate type to right)						
Diabetes						
Gout						
Heart disease						
High blood pressure						
Kidney disease						
Lung disease						
Lupus						
Psoriasis						
Tuberculosis						
Living						
Dead						
Other _________________						

PERSONAL HISTORY

Marital Status

☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered/significant other

Number of Children ☐ Are you currently employed? ☐ Yes ☐ No If yes, job title: ___________________________

If not employed, are you: ☐ Retired ☐ Disabled ☐ On sick leave?

HEALTH HABITS

☐	Never smoked
☐	Former smoker: year when you quit __________
☐	Currently daily smoker: average number of cigarettes per ***day*** __________
☐	Currently smoker on some days: average number of cigarettes per ***week*** __________

If you are a past or current smoker, approximately how many years have you smoked? __________

Which products do you use? Check all that apply: ☐ Cigarettes ☐ Cigars ☐ Pipe tobacco

Do you use nicotine gum or nicotine patches? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes, please select: beer wine hard liquor | How much?

Do you currently or have you use drugs recreationally? ☐ No ☐ Yes, please list:

Have you used IV drugs recreationally? ☐ No ☐ Yes, please list:

CURRENT MEDICATIONS

Prescription Medications	**Dosage or Strength** Examples: 500 mg, 25 mg/mL, etc.	**Route** Examples: by mouth, patch, injection, etc.	**Frequency (How often you take medication)** Examples: twice a day, every 2 hours, etc.

OTHER MEDICAL CARE: **Please list your primary care physician and any specialists that you are seeing.**

Name of Physician	**Specialty**	**City**
	Primary Care	

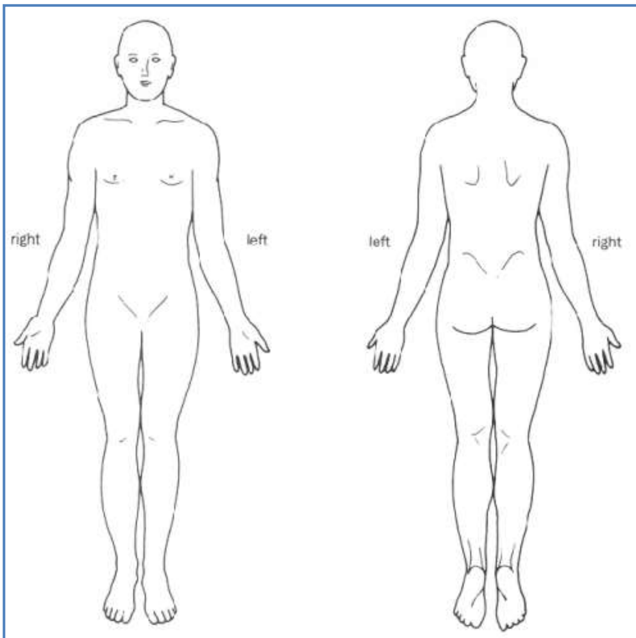
PLEASE SELECT ANY MEDICATIONS USED				
Acetaminophen	Mobic	Cymbalta	Baclofen	Dilaudid
Aleve	Motrin	Effexor / Venlafaxine	Carisoprodol / Soma	Hydrocodone / Norco / Vicodin
Aspirin	Naproxen	Gabapentin	Flexeril / Cyclobenzaprine	Morphine / Fentanyl patches
Diclofenac	Tylenol	Lyrica	Methocarbamal / Robaxin	Oxycodone / Percocet
Ibuprofen	Voltraren	Savella	Tizanidine / Zanaflex	Tylenol with codeine
Meloxicam		Tramadol		

Arava / Leflunomide	Imuran / Azathioprine	Rituxan / Rituximab		
Cellcept / Mycophenolate	Methotrexate	Self-injectables	no	yes: ____________________
Cytoxan	Plaquenil / Hydroxychloroquine	Infusion	no	yes: ____________________

Other ____

****************** **IF NO JOINT PAIN, SKIP THIS SECTION** ******************

Inform your specialist of the areas of JOINT PAIN that you have, using the diagram as reference.



PAIN HISTORY: PLEASE SELECT ANY APPLICABLE CONDITIONS AND FILL ANY APPLICABLE FIELDS	
Pain began	___ years ___ months ___ weeks
Quality of Pain	dull ache sharp shooting burning throbbing crushing
Pain travels?	no yes travels to _____________
Pain Frequency	constant intermittent
Joint swelling	no yes
Mark on the line the AVERAGE level of your pain in the past week: 0 1 2 3 4 5 6 7 8 9 10 no pain … worst pain imaginable	

Joint stiffness	none all day morning only lasting ____ mins. or ____ hrs.		
Other things that come with pain	fatigue nausea other ____		
Muscle weakness	all over	arms: left right both	legs: left right both
What makes the pain worse?	activity food stress weather changes humidity other _____________		
What makes the pain better?	activity medications nothing heat/massage other ________________		