RESTORE JOINTS & SPINE

MONARCH OBSTETRICS AND FAMILY MEDICINE

MISSION HEART & VASCULAR

NEW PATIENT QUESTIONNAIRE AND MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

Reason for Visit: _____ Side: Right / Left / Both

Primary Care Provider: _____

Who referred you: _____

If your injury the result of an accident please answer the following:

Date of Injury: _____ Where did it happen: _____

How did it happen: _____

Is it a Workers Comp Claim: Yes / No Was this a Motor Vehicle Accident: Yes / No

If not an injury, how long has it bothered you: _____

Have you taken ANY medications for this problem, (Prescription or OTC): _____

_____

Have you had any treatment for this problem (Doctors, Physical Therapy, etc.,): _____

Rate your pain/discomfort by circling: None = 1 2 3 4 5 6 7 8 9 10 = Severe

Quality of the pain (circle): Sharp Dull Throbbing Burning Other: _____

What makes your condition/injury better: _____

What makes your condition/injury worse: _____

ALLERGIES NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg. pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

VACCINATION HISTORY

Last Tetanus Booster or Tdap:
Last Flu Vaccine:
Last Zoster Vaccine *(Singles)*:
Last Pnuemovax *(Singles)*:
Last Prevnar:

HEALTH MAINTENANCE SCREENING TEST HISTORY

Cholesterol	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
Bone DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

RESTORE JOINTS & SPINE

MONARCH OBSTETRICS AND FAMILY MEDICINE

MISSION HEART & VASCULAR

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypetension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(Kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(Specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:
Total Number of Pregnancies:
Pregnancy Complications:
Age of First Menstration: ____ Age of Menopause: ____
Number of Live Births:

FAMILY MEDICAL HISTORY

NO SIGNIFICANT FAMILY HISTORY IS KNOWN

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer *(Type:_____)*	Emphysema *(COPD)*	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other: _____																		

RESTORE JOINTS & SPINE

MONARCH OBSTETRICS AND FAMILY MEDICINE

MISSION HEART & VASCULAR

SOCIAL HISTORY

Occupation *(or prior occupation)*:	○ Retired ○ Unemployed ○ LOA ○ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift?	
Marital Status *(Check one)*: ○ Single ○ Partner ○ Married ○ Divorced ○ Widowed ○ Other: _____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

Tobacco USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol/Drug Use)*		
Current: Packs/day _____ # of Years _____	**Past:** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(Check one)*: ○ Pipe ○ Cigar ○ Snuff ○ Chew			
Alcohol/DRUG USE	Do you drink alcohol? Y N	○ Beer ○ Wine ○ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			
Sexual Activity	Sexually involved currently? Y N *(if no sexual history, please continue to Exercise)*		
Sexual partner(s) is/are/have been: ○ Male ○ Female			
Birth control method: ○ None ○ Condom ○ Pill/Ring/Inj/IUD ○ Vasectomy			
Exercise	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*		
What kind of exercise?		***Duration:*** How long (min):_____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night? *(or during the day, if working nightshift?)*		
DIET	How would you rate your diet? ○ Good ○ Fair ○ Poor	Would you like advice on your diet? Y N	
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N	
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N	
Is violence at home a concern for you? Y N	Have you completed an Advanced Director for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N		

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other: _____		
Other: _____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deplyed? Y N	If yes, where?

Patient Name: _____ Date of Birth: _____

RESTORE JOINTS & SPINE

MONARCH OBSTETRICS AND FAMILY MEDICINE

MISSION HEART & VASCULAR

REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLIES

CONSTITUTION		**CARDIOVASCULAR**		**SKIN**	
☐	Activity change	☐	Chest pain	☐	Color change
☐	Appetite change	☐	Leg swelling	☐	Pallor
☐	Chills	☐	Palpitations	☐	Rash
☐	Diaphoresis	**GASTROINTESTINAL**		☐	Wound
☐	Fatigue	☐	Abdominal distention	**ALLERGY/IMMUNO**	
☐	Fever	☐	Abdominal pain	☐	Environmental allergies
☐	Unexpected weight change	☐	Anal bleeding	☐	Food allergies
HEAD, EAR, NOSE & THROAT		☐	Blood instool	☐	Immunocompromised
☐	Congestion	☐	Constipation	**NEUROLOGICAL**	
☐	Dental problem	☐	Diarrhea	☐	Dizziness
☐	Drooling	☐	Nausea	☐	Facial asymmetry
☐	Ear discharge	☐	Rectal pain	☐	Headaches
☐	Ear pain	☐	Vomiting	☐	Light-headedness
☐	Facial swelling	**ENDOCRINE**		☐	Numbness
☐	Hearing loss	☐	Cold intolerance	☐	Seizures
☐	Mouth sores	☐	Heat intolerance	☐	Speech difficulty
☐	Nosebleeds	☐	Polydipsia	☐	Syncope
☐	Postnasal drip	☐	Polyphagia	☐	Tremors
☐	Rhinorrhea	☐	Polyuria	☐	Weakness
☐	Sinus pressure	**GENITOURINARY**		**HEMATOLOGIC**	
☐	Sneezing	☐	Difficulty urinating	☐	Adenopathy
☐	Sore throat	☐	Dysuria	☐	Bruises/bleeds easily
☐	Tinnitus	☐	Enuresis	**PSYCHIATRIC**	
☐	Trouble swallowing	☐	Flank pain	☐	Agitation
☐	Voice change	☐	Frequency	☐	Behavior problem
EYES		☐	Genital sore	☐	Confusion
☐	Eye discharge	☐	Hematuria	☐	Decreased concentration
☐	Eye itching	☐	Penile discharge	☐	Dysphoric mood
☐	Eye pain	☐	Penile pain	☐	Hallucinations
☐	Eye redness	☐	Penile swelling	☐	Hyperactive
☐	Photophobia	☐	Scrotal swelling	☐	Nervous/anxious
☐	Visual disturbance	☐	Testicular pain	☐	Self-injury
RESPIRATORY		☐	Urgency	☐	Sleep disturbance
☐	Apnea	☐	Urine decreased	☐	Suicidal ideas
☐	Chest tightness	**MUSCULAR**			
☐	Choking	☐	Arthralgias		
☐	Cough	☐	Back pain		
☐	Shortness of breath	☐	Gait problems		
☐	Stridor	☐	Joint swelling		
☐	Wheezing	☐	Myalgias		
☐		☐	Neck pain		
☐		☐	Neck stiffness		

Patient Name: _____ Date of Birth: _____