PROLIANCE ORTHOPEDIC ASSOCIATES

Specializing in What Moves You

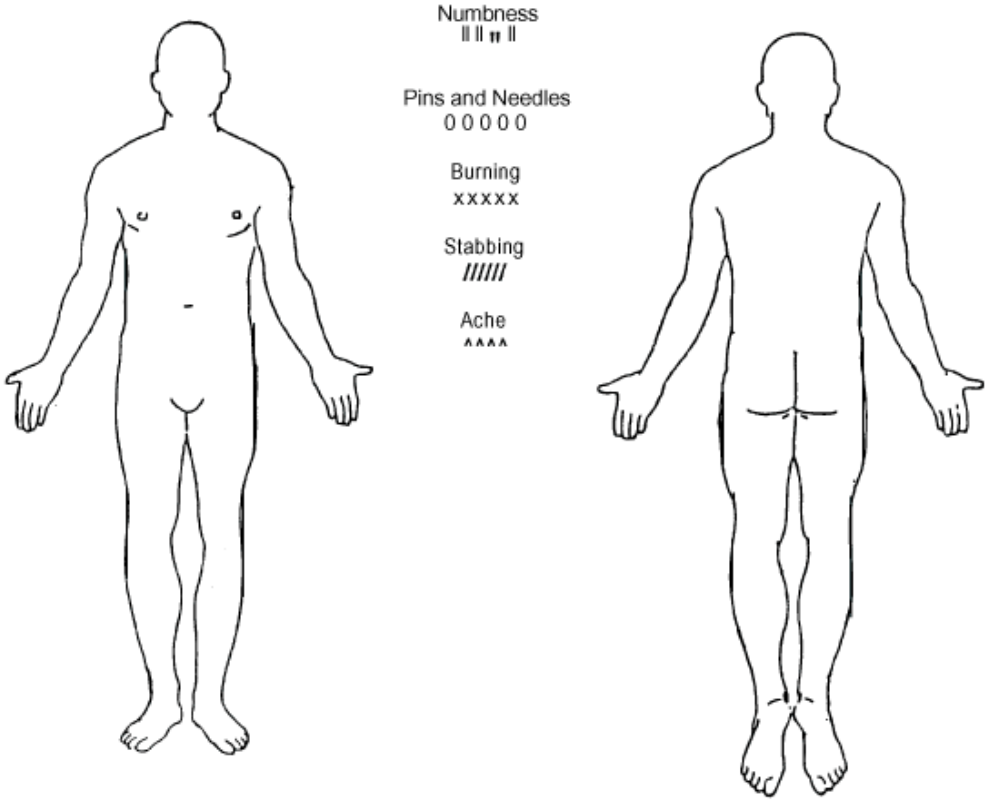
Date: New Patient Form

Name: _____ Sex: M F Age: ____Height: _____Weight:_____
Name of Family Doctor:_____Dominant Hand: R L

Present Complaint: (Please describe the symptoms for which you are being seen today):
_____Date of Onset: _____
Was the onset of pain related to: work injury auto accident other unknown
Describe work injury or accident: _____
List activities that make your symptoms worse: _____
List activities that make your symptoms better: _____
Any previous treatment for this problem? (Include any previous medication prescribed):
_____
_____

Please rate your pain in the following areas and diagram your pain below:

Neck	no pain	0 ----------10	worst pain
Arm	no pain	0 ----------10	worst pain
Back	no pain	0 ----------10	worst pain
Leg	no pain	0 ----------10	worst pain



Right Left Left Right

PLEASE FILL OUT BACK SIDE OF FORM

Past Medical History: Have you ever had any of the following?

Anemia	No	Yes	Glaucoma	No	Yes
Angina	No	Yes	Gout	No	Yes
Anxiety	No	Yes	Heart Attack	No	Yes
Arthritis	No	Yes	Heart Arrhythmia	No	Yes
Dental Problems	No	Yes	High Blood Pressure	No	Yes
Bladder Infection	No	Yes	HIV/AIDS	No	Yes
Blood Clots	No	Yes	Liver Hepatitis	No	A B C
Cancer	No	Yes	Psychiatric Problem	No	Yes
Where? _____			Stomach Ulcers	No	Yes
Depression	No	Yes	Stroke	No	Yes
Diabetes	No	Yes	Thyroid Disorder	No	Yes
Emphysema	No	Yes	Tuberculosis	No	Yes
Epilepsy (seizures)	No	Yes	Other Illness: _____		
Fracture (broken bone)	No	Yes	_____		
If yes where? _____			_____		

Allergies to medications, tapes, latex, dyes, and topical solutions, list medication and reaction:

_____

Check here if no known allergies ( )

Non-orthopedic (bone and joint) surgery:

_____

Social History:

Are you married? No Yes Do you have children? No Yes ages_____

Occupation?_____ Where do you work?_____

If unemployed, when did you last work? _____

Do you smoke? No Yes If yes, how much? _____ packs per day for _____years

If no, did you ever? _____years_____packs per day_____year quit

Do you drink alcohol? No Yes How much? _____ How often? _____

Do you have a history of street drug use? No Yes IV drug abuse? No Yes

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The above information is correct to the best of my knowledge.

Patient Signature _____ Date _____
