Date:	***St. Clair Orthopaedics*** ***Dr. Perry New Patient Form***	Chart #

NAME_____

Age:_____yrs Height:_____ Weight:_____

Optional: (leave blank if decline)

Race:_____Ethnicity:_____

Primary Care Physician _____ Referred by:_____

Circle the correct choice….

Problem Area: **Left** **Right** **Both**

Back Hip Thigh Knee Leg Ankle Foot Toes

How long have you had pain/symptoms:_____

Did you have an injury: **YES** **NO**

If yes, when/where:_____

Is this AUTO or WORKERS COMP: **YES** **NO** *Last work date:*_____

Recent studies: **Yes** (Where & When) : **X-rays** **MRI** **CT** **EMG**

PREVIOUS Treatments for Current Problem: Circle what applies

Physical Therapy Injections Surgery Brace Cane/Walker

Medications for this problem:_____

What is your pain level: **0 1 2 3 4 5 6 7 8 9 10**

Do you have any Numbness or Tingling: YES NO

If yes, where:_____

Please circle your current symptoms:

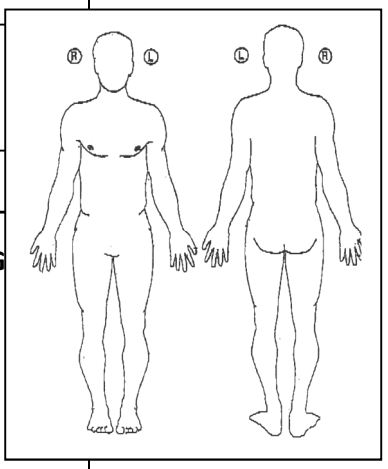
Mechanical: Clicking ~ Popping ~ Grinding ~ Clunking ~ Giving Away ~ Locking up

Problem is made worse by: Walking Bending Running Stairs Lifting

Timing of Symptoms: During activity At rest During night

How often: Constant Occasional Only with Activity

Mark the Location of pain



**Please flip to back side

Circle *the correct choice….*

Past Medical History: NONE or ***High blood pressure***
Heart disease Stroke Blood Clots Asthma Ulcers Diabetes Anemia
Depression/Bipolar Thyroid HIV Alcoholism Hepatitis: A B C
Cancer_____ Other:_____

Past Surgical History: **NONE or List Surgery date, type & right/left:**

_____

_____

Family History: NONE

Diabetes Fibromyalgia Arthritis Heart Disease

Father's history: Mother's history: _____

Does your mother or father have their joints replaced?_____

Marital status: Single Married Divorced Widowed #KIDS___

Occupation _____ Retired_____ Disabled_____

Sports/Hobbies/Exercises_____

Do you smoke: → *Yes:_____packs/day* *or* *NO*

Height: ___Ft. ___in **Weight: _____Lbs.**

Allergies to medications: NONE or

Please List_____

Medications: **Do not include vitamins/supplements;* *NAMES only*

_____

_____

Are you currently on a blood thinner? If so, which one:_____

Review of symptoms: NONE or Please circle what applies:

Fevers/chills night sweats weight loss/gain chest pain

shortness of breath irregular heart beat wheezing/asthma/cough

heartburn nausea jaundice hay fever hot flashes acne

depression/anxiety bipolar suicidal

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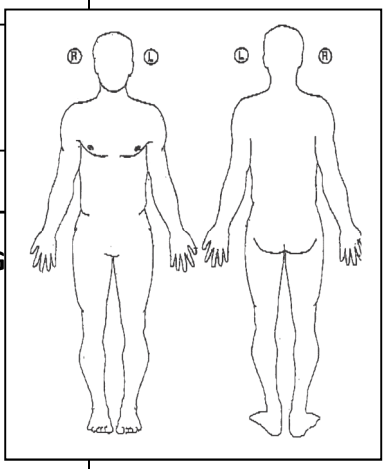

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