Date:	**_St. Clair Orthopaedics_** **_NJS 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 ***Are You:*** Right or Left Handed

Neck Shoulder Arm Elbow Forearm Wrist Hand Finger

Back Hip Thigh Knee Leg Ankle Foot Toes

What is the severity of the pain? 0 1 2 3 4 5 6 7 8 9 10

What is the type of pain? Sharp Dull Burning Intermittent Constant

What are the mechanical issues? Clicking Popping Giving way

Clunking Grinding Locking up

Does the pain radiate? Yes No

Does swelling occur? Yes No If Yes, where? __________________

Is there numbness or tingling? Yes No If Yes, where? __________________

When do these symptoms occur? In the morning During activity After activity

At rest End of day During night

Symptoms are worsened by… Walking Running Stairs Bending

Reaching Lifting Sports

When did the problem start? Last week 2 weeks 1 month 3 months

6 months Over a year ago Date: _______

Was the onset… Slow/gradual Sudden/sharp

Is this AUTO or WORKERS COMP? Yes No

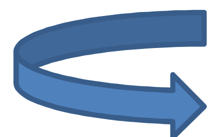
Is there a LAWSUIT related to this problem? Yes No

Previous tests? X-rays MRI CT scan EMG Bone scan Ultrasound Labs None

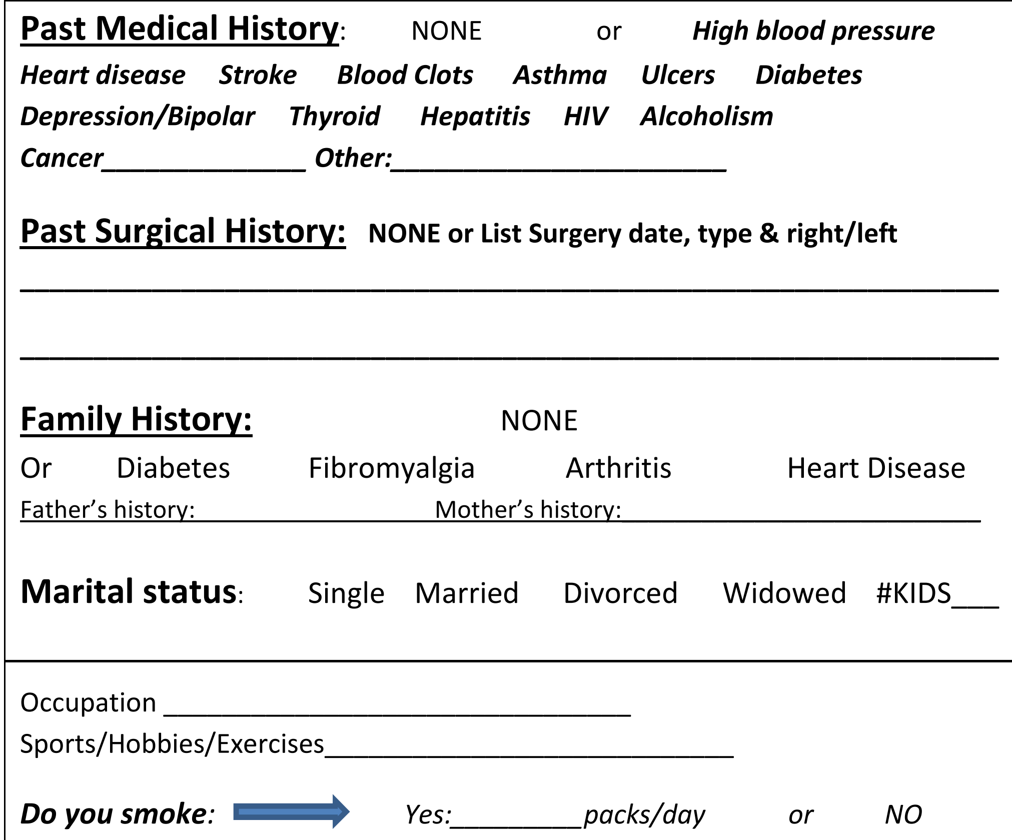
Previous treatment? Rest Splint Cast Crutches Medications

Physical therapy Surgery Injections None

**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

Depression/Bipolar Thyroid Hepatitis HIV Alcoholism

Cancer______________ Other:_______________________

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

____

____

Family History: NONE

Or Diabetes Fibromyalgia Arthritis Heart Disease

Father's history:_____________ Mother's history:_____________

Marital status: Single Married Divorced Widowed #KIDS___

Occupation _________________________________

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*

____

____

Review of systems: 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