Southern California
Bone & Joint Clinic

ORTHOPAEDIC SURGERY
NEW PATIENT INFORMATION FORM

Date:______________

Name:____

Height:__________ **Weight:**__________ **Age:**__________ **BMI:**___________

Reason for today's visit:____

____

Date of injury or onset of complaints: ____

Is this injury work related? □ Yes □ No; Employer___________________________
Currently Working? □ Yes □ No; Last day worked: __________________________
Auto Accident and/or litigation? □ Yes □ No

Primary Care Physician and Phone Number: ____
Referring person (If not the same as Primary Care Physician) : ____________________________________

Medical Problems	YES	NO	Please detail ALL "YES" ANSWERS
Eye, Ear, Nose, Throat			
Heart Disease			
Lung Disease			
Kidney/Liver Disease			
Stomach/Intestinal Disease			
Arthritis/Bone/Joint Muscle Disease			
Diabetes			
Epilepsy			
Cancer			
Vascular Disease			
Thyroid Disease			
High Blood Pressure			
Bleeding/Clotting Disorders			
Psychiatric Problems			
Other:			

Surgeries (type and date): ____

____

Hospitalizations (other than for surgeries above): ____

____

Current Medications (list all medications including prescription, over the counter, vitamins & supplements) **:** ____

____

Allergies (or bad reactions) to medications: ____

____

Social History:
Do you use Tobacco? □ Yes □ No Amount/Duration: ____________________________
Do you use Alcohol? □ Yes □ No Amount/Duration: ____________________________
Do you use Recreational Drugs? □ Yes □ No If Yes, what substance(s)? ________________________
Amount/Duration: _________________________

TURN OVER

Occupation (w/ brief job description): ____
Highest Level of Education: ____
Recreational Activities: ____

Family History: ____

____

✓	**System Review**: Check those that apply	**Explain**
	Headache/dizziness/visual disturbances	
	Throat trouble, ringing in ears, runny nose	
	Chest pain/palpitations/irregular heart beat	
	Shortness of Breath/cough	
	Heartburn/nausea/vomiting	
	Burning/frequency of urination or vaginal discharge	
	Muscle/bone/joint/pain or stiffness	
	Changes in skin color/texture/moles or rashes	
	Swelling, discoloration/temperature change of extremity	
	Loss of sensation	
	Lower back pain	
	Fever/chills/sweats/fatigue	
	Easy bruising, bleeding disorder, or **blood clots**	
	Weight loss or gain	
	Excessive thirst or hunger	
	Excessive worry/anxiety/depression or trouble sleeping	
	Dietary restriction	
	Glasses or contacts	
	Dentures or partials	

Patient Signature:____Date:______________

Physician Signature of Initial Review: ______________________________Date:______________

Periodic updates:
Date: ___________Changes made? Yes ___ NO _____Physician/ staff signature ____________________

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Periodic updates:
Date: ___________Changes made? Yes ___ NO _____Physician/ staff signature ____________________

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Periodic updates:
Date: ___________Changes made? Yes ___ NO _____Physician/ staff signature ____________________

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