# St. Jude Heritage Orthopedic Surgery: New Patient Form

**Patient Name**: _____ **DOB**: _____ **Age**: _____

Occupation / School: _____ **Sex:** ☐ M ☐ F

Referral Source: _____

Primary care doctor / Family doctor: _____

Dominant Hand: ☐ Right ☐ Left

**Reason for Visit**: _____

**Details of Injury:**

Date your pain/problem started: _____

Briefly describe what happened: _____

_____

Have you been treated for this condition in the past? _____

If yes, by whom? _____

Type of treatment you had in the past for this condition? (Such as X-Ray/MRI, medications, injection, physical therapy, surgery)

_____

Cortisone injection in the past? _____ If yes, when? _____

Did it help, and for how long? _____

Were you seen in the ER for this condition? _____

If yes, when? _____

**Past Medical History:**

☐ Blood Clot or Pulmonary Embolus (PE)

☐ Diabetes ☐ Stroke ☐ Stomach ulcers

☐ Seizures ☐ Cancer ☐ High Cholesterol

☐ High blood pressure ☐ Heart disease

Do you take **blood thinners**? (List) _____

Past surgeries (with date, continue on back if needed)

_____

_____

Problems with anesthesia? _____

Smoke? _____ How many packs per day? _____

How many years of smoking? _____

How much alcohol do you drink per day?

☐ None ☐ 1-2 per week ☐ 1-2 ☐ 3-5 ☐ >5

Do you smoke marijuana? _____

If so, how often? _____

Do you use any other drugs? (list) _____

What are your usual activities?

(For work, school, sports, exercise, etc.) _____

**History of Present Illness:**

A) Where is your pain located? (List the body part(s), joint(s), and location: front side or back?)

_____

B) How bad is your pain? Between 0 (least) and 10 (worst), what number best describes your current pain: _____

C) Character of the pain? Please circle: dull, sharp, achy, burning, throbbing, cramping, dull, shooting, incapacitating, prickly, stabbing; if other, Describe:_____

D) Any popping or clicking? _____How far can you walk? _____ Can you climb stairs? _____

E) Associated Symptoms? Please circle: swelling, locking, giving away, tenderness, fatigue, bruising, tingling, numbness, radiating pain, if other, Describe:_____

F) What makes your symptoms better? Please circle: NDSAIDs, other medications, Injections, rest, heat, cold, elevation, physical therapy, braces, special positioning. If other, Describe:_____

G) Do you use a brace? ____ If yes, what type? _____

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ Date: _____

*For Office Use: Name (last, first)* _____ *DOB* _____ *MRN* _____

*Date of visit*_____