NEW PATIENT/CONSULTATION FORM

Patient Information. Medical History

DATE: _____

NAME: Last _____First_____Initial_____

Date of Birth: _____ □ M □ F Social Security#_____

Referred By: _____Primary Doctor: _____

PAST MEDICAL HISTORY

Current Medication List

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies:

☐Penicillin ☐Sulfa Drugs ☐Aspirin ☐Codeine ☐ Iodine/Shellfish

☐Local Anesthetics ☐General Anesthetics ☐ Latex ☐ Tape

☐Other antibiotics ☐Other pain medications ☐Non-steroidal medications

_____ _____ _____

_____ _____ _____

Medication Allergies: _____

Food Allergies: _____

Environmental Allergies: _____

Current Problems: (Location, Duration, Onset, Course, Aggravating Factors, Previous Treatment)

_____ **Length of time for current problem:**

_____ **□ Days**

_____ _____ **□ Weeks**

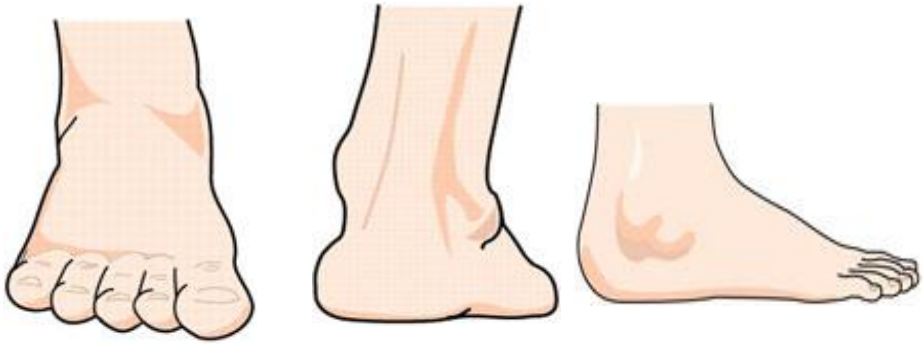
_____ **□ Months**

_____ **□ Years**

_____

Please use circles and arrows to indicate painful, injured or problem area(s)

_____Right _____Left



PLEASE FILL OUT BACKSIDE

ILLNESSES

□MAJOR DISEASE:
□Diabetes
□Hypertension
□Angina
□Heart Disease
□Arrhythmia
□Murmur
□Mitral Valve Prolapse
□Stroke
□Chest Pain

HEENT:
□Headaches
□Eye Problems
□Hearing Problems

RESPIRATORY:
□Asthma
□Bronchitis
□Frequent Colds
□Lung Disease
□Shortness of Breath
□Tuberculosis
□Emphysema

ARTHRITIS:
□Osteoarthritis
□Rheumatoid
□Gout
□Sero-negative: Reiter's, P&A, Anklyosing Spondylitis, CCPD, Irritable Bowel

VASCULAR:
□Anemia
□Sickle Cell
□Bleeding Disorders
□Poor Circulation
□Night Cramps
□Leg Pain When Walking
□Vein Problems
□Spider Veins
□Varicose Veins
□Swelling Phlebitis
□Leg ulcerations
□Blood Clots
□Transfusions

GASTROINTESTINAL
□Ulcers **□Bowel Disorders**
□Stomach Problems **□GI or Rectal Bleeding**
□Hiatal Hernia **□Acid Reflux (GERD)**

MISCELLANEOUS:
□Epilepsy
□Thyroid Disease
□Muscle Disease
□Kidney Problems
□Bladder Problems
□Prostate Problems
□Venereal Disease
□Skin Conditions
□Cancer History
□Hepatitis

PSYCHOLOGICAL
□Anxiety
□Depression
□Psychiatric Conditions
□Drug Dependence
□Alcohol Dependence

OTHER ILLNESSES:
_____
_____

SOCIAL HISTORY:
Occupation: _____

Athletic Activities: _____

□Single
□Married
Alcohol: _____ oz/day/week
Tobacco: ____pks/d for ____ yrs

FAMILY HISTORY: _____

I herby give my permission to Dr. Cardon or Dr. Johnson to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature or Responsible Party_____ Date: _____