ORLANDO HEALTH

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NEW PATIENT HISTORY

Date: _____

Name: _____ Date of Birth: _____

Age: _____ Sex: ☐ M or ☐ F Handedness: ☐ Left or ☐ Right

Who filled out this form: _____

Who referred you to our clinic (full name)
Name: _____
Address: _____
_____
_____

Who is your Primary Care physician (full name)?
Name: _____
Address: _____
_____
_____

What is the main issue you want us to address?

Do not write on the right hand panel here or on subsequent pages.

PAST MEDICAL HISTORY:

Medication Allergies: ☐ No ☐ Yes (list):

List **all** your **current** medications; use another sheet if needed (dose & frequency):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Medical Problems (check all that apply):

☐ Arthritis	☐ Diabetes Mellitus	☐ Cancers/Tumors
☐ Strokes	☐ TIAs (mini strokes)	☐ Stomach Disorders
☐ Hypertension	☐ Heart Disease	☐ Infectious Diseases
☐ Anemia	☐ Lung Disease	☐ Thyroid Disease
☐ Seizure	☐ High Cholesterol	☐ Tuberculosis
☐ Gout	☐ Kidney Disease	☐ Liver

Do you drink? ☐ Yes Stopped: _____ Never did

Do you smoke? ☐ Yes Stopped: _____ Never did

Patient Name: _____ **Date of Birth:** _____

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NEW PATIENT HISTORY

PAST SURGICAL HISTORY: (list dates, type)

1. _____
2. _____
3. _____
4. _____
5. _____

PAST PSYCHIATRIC HISTORY:

Which of these clinicians have you seen, if ever: ☐ N/A
☐ a psychiatrist, ☐ a psychologist, ☐ a counselor,
☐ a therapist?

Have you ever used medications for depression?
☐ Yes ☐ No

Have you ever used medications for anxiety?
☐ Yes ☐ No

Have you ever required medications for any other psychiatric condition? If "Yes," what condition?
☐ Yes ☐ No

Have you ever abused or misused prescription medications?
☐ Yes ☐ No

Have you ever had a drinking problem?
☐ Yes ☐ No

Have you ever used street drugs?
☐ Yes ☐ No

Have you ever participated in a drug or alcohol rehabilitation program? If "Yes," what type & when?
☐ Yes ☐ No

Have you ever been hospitalized for a psychiatric reason? If "Yes," when, where and why?
☐ Yes ☐ No

FAMILY HISTORY:

Please list all disorders/diseases that seem to run/occur in your "**blood**" relatives. Include relation to you.

1. _____
2. _____
3. _____

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REVIEW OF SYSTEMS: (Check all that apply to you)

☐ Chills or Fever	☐ Poor Appetite
☐ Dizziness	☐ Recent weight change
☐ Headaches	☐ Blood in bowel movements
☐ Blackouts	☐ Hemorrhoids
☐ Vision problems	☐ Bowel problems
☐ Wear Glasses	☐ Urinary problems
☐ Hearing Problems	☐ Burning on urination
☐ Hoarseness	☐ Difficulty starting urination
☐ Wears dentures	☐ Difficulty stopping urination
☐ Difficulty swallowing	☐ Every night to urinate
☐ Difficulty chewing	☐ Rashes
☐ Stomach Pain	☐ Hot or cold spells
☐ Nausea	☐ Nervous exhaustion
☐ Vomiting	☐ Trouble sleeping
☐ Frequent Loose Stools	☐ Depression
☐ Constipation	☐ Nervous tension
☐ Diarrhea	☐ Stomach ulcer
☐ Gastritis	☐ Other _____

FALLS ASSESSMENT:

Have you fallen lately? ☐ Yes ☐ No
Have you fallen in the past month? ☐ Yes ☐ No

TB SCREEN

Have you or any member of your household, been exposed to TB? ☐ Yes ☐ No

Check the boxes if the answer is yes.

☐ (3 points) Cough no longer than 2 weeks
☐ (5 points) Blood in sputum
☐ (2 points) Fevers or night sweats
☐ (2 points) Recent unexplained weight loss of > 10lbs
☐ (2 points) Recent exposure to TB
☐ (5 points) History of TB, or active TB (even if on meds.)
☐ (2 points) Jail in the past two years
☐ (2 points) HIV positive
☐ (1 point) Homeless or living in a shelter
☐ (1 point) Foreign born (Asia, Eastern Europe, Latin America, Africa)

Total Points: _____ If the patient has received five or more points, place a TB mask on the patient and place in a private room.
Use Airborne Precautions.

Screening completed By: _____ Title: _____ Date/Time: _____

Patient Name: _____ **Date of Birth:** _____

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Do you have a History of MRSA/VRE
(Methicillilna Resistant Staphylococcus Aureus /Vancomycin Resistant Enterococcus)
☐ Yes ☐ No
(Staff If yes, initiate MRSA/VRE Protocol)

WOMEN'S ONLY:

☐ Postmenopausal
☐ Vaginal Discharges
☐ Irregular Periods
☐ Frequent Spotting
☐ Take Birth Control Pills
☐ Could Be Pregnant
☐ Date of Last Period
☐ Other _____

SOCIAL HISTORY:

Domestic Situation

What city do you live in? _____

You are: ☐ Married ☐ Separated ☐ Divorced
☐ Widowed ☐ Single

How many children do you have? _____
List age(s): _____

Who currently lives with you? _____

You live in:
☐ An apartment
☐ A manufactured home: ☐ single wide ☐ double wide
☐ A house:
How many floors: _____
How many steps to enter: _____
Your bed & bathroom are on which floor: _____
☐ Other

Are there any substance abuse issues in your family or household?
If "Yes", who and what type of substance?
☐ Yes ☐ No

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NEW PATIENT HISTORY

ABUSE/DOMESTIC VIOLENCE:

Do you have a history of current or past physical or emotional abuse?
☐ Yes ☐ No
History:

Is there a history of current domestic violence?
☐ Yes ☐ No

EDUCATION & TRAINING:

How far did you go in your education?

What other training have you had?

Any education barriers / preferences?

EMPLOYMENT HISTORY:

Are you currently employed? ☐ Yes ☐ No
If "Yes," what is your job title/position? _____
☐ Full time, hours per week _____
☐ Part time, hours per week _____
☐ Without restrictions
☐ With restrictions:

If "No," are you: ☐ Disabled, how long? _____
☐ Retired, how long? _____
☐ Other _____

Are you a homemaker? ☐ Yes ☐ No

Are you a student? ☐ Yes ☐ No

OTHER ACTIVITIES

Please list the hobbies, sports, or other activities you **currently** participate in:

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NEW PATIENT HISTORY

HISTORY OF CURRENT COMPLAINT(S):

What is the main reason for your referral?

When did this condition start?

Have you had a similar condition before?
☐ No
☐ Yes, When:

Was onset: ☐ Slow or ☐ Rapid?

What do you think caused your condition?

If you were referred for other than a ***pain problem,***
GO directly to the page 8.

PAIN SECTION:

Your pain: ☐ Comes and Goes ☐ Is Constant
What make your pain feel **better**?

☐ Sitting	☐ Standing	☐ Physical Therapy
☐ Heat	☐ Walking	☐ Occupational Therapy
☐ Rest	☐ Laying down	☐ Massage Therapy
☐ Ice	☐ Stretching	

☐ Medicine (which ones?)_____
☐ Others _____

What makes your pan feel **worse**?

☐ Sitting	☐ Standing	☐ Physical Therapy
☐ Lifting	☐ Twisting	☐ Occupational Therapy
☐ Walking	☐ Laying down	☐ Massage Therapy

☐ Coughing, sneezing, straining at stool
☐ Others _____

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Pain Scale

On the scales below, "**0**" represents no pain and "**10**" represents the most severe pain you can imagine.

Use an "**X**" to mark your most severe pain and an "**O**" to mark your next most severe pain, if you have another.

Place a mark over the number that best describes your pain at its ***least*** during the last 30 days.

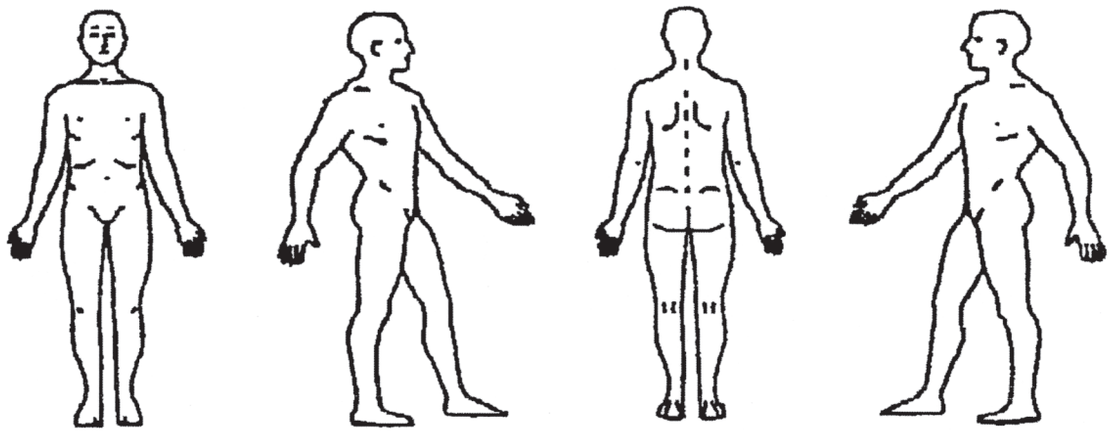
0 1 2 3 4 5 6 7 8 9 10

Place a mark over the number that best describes your pain at its ***worst*** during the last 30 days.

0 1 2 3 4 5 6 7 8 9 10

Pain Diagram

On the diagram below, **shade** the area(s) where you feel pain. "**X**" the area that hurt the most and an "**O**" for the next most painful area, if you have one.



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How ***severely*** has your ***present*** condition affected the following areas?
(Place a "✓" in the appropriate box in ***each*** row or write "**NA**" if Not Applicable.)

	Severely Affected	Moderately Affected	Slightly Affected	Not Affected
Sleep				
Mood				
Walking				
Appetite				
Enjoyment of Life				
Ability to Concentrate				
Relations with Other People				
Normal Work Routine at Home				
Normal Work Routine on the Job				
Participation in Recreational or Exercises				

How much ***assistance*** do you ***presently*** need with the following ***activities of daily living***?
(Place a **"✓"** in the appropriate box in ***each*** row.)

	Total Assistance	Moderate Amount of Assistance	A Little Assistance	A Device is Needed	No Assistance
Getting out of a bed					
Getting up from or sitting down into a chair					
Upper body dressing					
Upper body bathing					
Lower body dressing					
Lower body bathing					
Hygiene after a bowel movement					
Walking					

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EVALUATION AND TREATMENT SECTION

Please list all of the **physicians** that have seen or treated you for your **current** condition. Include name, specialty, facility, and date they saw you.

Please list all **tests** done (for example MRIs, X-rays, blood work, etc.) for your **current** condition. Include name of test(s), result(s) (if known), and date(s) preformed.

Please list all **medications** you have used in the **past** for your **current** condition.

Please check below any **therapy** you have had for your **current** condition, indicating the start and completion dates.

☐ PT
☐ OT
☐ Speech Therapy
☐ Injections
☐ Other: _____

Please check below any equipment / devices you have used for your **current** condition.

☐ Cane(s) ☐ Walker(s) ☐ Wheelchair
☐ TENS Unit ☐ Braces
☐ Other: _____

Please list all **hospitalization(s)** you may have had for your **current** condition. Include facility, service, and dates.

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Please add any additional information that you want the doctor to be aware that you feel is important in your care.

Are you present involved in a lawsuit related to your current complaint(s)?
☐ Yes ☐ No
If “Yes”, please explain.

_____ Date: _____
(Patient Signature)

_____
(Print name)