

# NEW PATIENT INFORMATION SHEET

## Dr. Paul Abeyta

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### MEDICAL HISTORY

Who referred you? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

How did you hear about us?  Physician  Family  Website  Physical Therapist

Last Name \_\_\_\_\_ Mi \_\_\_\_\_ First Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

DOB \_\_\_\_\_ WT \_\_\_\_\_ HT \_\_\_\_\_

**Are you being treated for any medical diseases?** (example: diabetes, osteoporosis, heart, lungs, ulcers, pulmonary emboli, high blood pressure)

**1** \_\_\_\_\_ **3** \_\_\_\_\_

**2** \_\_\_\_\_ **4** \_\_\_\_\_

**Surgical History:** Please list any surgeries or orthopedic injuries with approximate dates

**1** \_\_\_\_\_ **3** \_\_\_\_\_

**2** \_\_\_\_\_ **4** \_\_\_\_\_

Current Medications (list here or attach list)

Allergies to Medications:

**1** \_\_\_\_\_ **3** \_\_\_\_\_

**2** \_\_\_\_\_ **4** \_\_\_\_\_

Do you smoke?  No  Yes If yes, how many Packs per day?: \_\_\_\_\_ Former Smoker? \_\_\_\_\_

Alcohol?  Never  Occasionally  Daily

History of bleeding disorders?  No  Yes

If Yes, Describe:

If there are any rare or unusual diseases in your family, please list:

**1** \_\_\_\_\_ **3** \_\_\_\_\_

**2** \_\_\_\_\_ **4** \_\_\_\_\_

Sports/Activities: \_\_\_\_\_

Currently working?  No  Yes If yes type of work: \_\_\_\_\_

# New Patient Information Sheet

## PAIN DIAGRAM

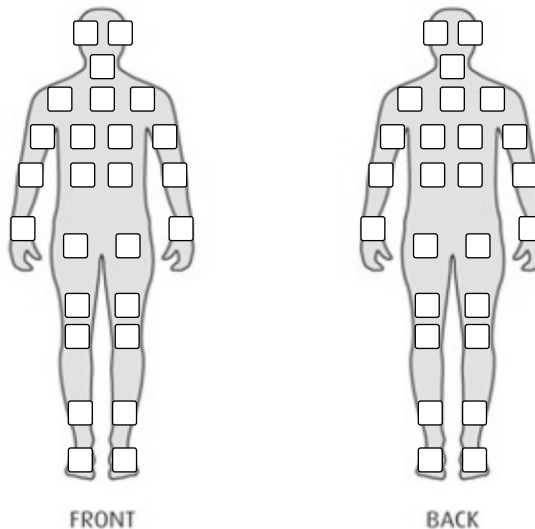
Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_ Date: \_\_\_\_\_

Check the number that describes the severity of your pain:

No Pain  1  2  3  4  5  6  7  8  9  10  Worst Pain

Mark on the body outline areas where you feel the described sensations. Use the appropriate symbol:

Numbness : -----  
 Burning : xxx xxx xxx  
 Pins & Needles : ooo ooo ooo  
 Pain : /// /// ///



## REVIEW OF SYSTEM

Please check any that apply: (if none apply, check the box indicating that none apply)

### Constitutional

- Fevers/ Chills/ Sweats
- Unexplained weight gain/ loss
- Excessive thirst or urination

Physician Comments \_\_\_\_\_

### Cardiovascular

- Chest Pain
- Palpitations

Physician Comments \_\_\_\_\_

### Respiratory

- Cough/ Wheeze
- Difficulty breathing

### Gastrointestinal

- Blood in bowels
- Abdominal pain
- Nausea/ Vomiting
- Diarrhea

### Neurologic

- Headaches
- Dizziness/ Light Headedness
- Numbness
- Loss of Coordination

### Mental Health

- Anxiety/ Stress
- Trouble Sleeping
- Depression

### Skin/ Integument

- Eczema
- Rash

### Genitourinary

- Incontinence
- Retention
- Recurrent UTI

### Hematologic/ Lymphatic

- Excessive Bleeding
- Easy Bruising

### Rheumatologic

- Rheumatoid arthritis

### Endocrine

- Diabetes

### Other/ Not Listed:

- None Apply/ No Symptoms

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed and discussed this with the patient.