NEW PATIENT INFORMATION SHEET
OFFICE OF J.C. Chavez PA-C

Today's Date:

Patient Name:

GENERAL INFORMATION

Who referred you to this office? ____

Who is your Primary Care Medical Doctor? __________________________________

Age:________ Height:________Weight:________ ☐ Right Handed ☐ Left Handed

Current Occupation:____

Do you Exercise Regularly? ☐ No ☐ Yes Type of Exercise:___________________

Frequency of Exercise: ______ minutes ______ x per week

What sports or hobbies do you participate in? _________________________________

HEALTH EVALUATION

Reason for visit today? ☐ Right ☐ Left

☐ Foot ☐ Ankle ☐ Knee/leg ☐ Hip/thigh ☐ Shoulder/arm
☐ Elbow/forearm ☐ Wrist/hand ☐ Back

What brings you to the office today? _________________________
____

When or how long ago did this start? __________________________

Was there an accident or an activity that started this?

____

What are your current symptoms? (pain, stiffness, popping, numbness,
weakness, giving way, etc) __________________________________

____

What makes the condition worse? ____________________________

What makes the condition better? ____________________________

I have tried the following treatments:

☐ Orthotics ☐ Cast/brace ☐ Medication ☐ Physical therapy ☐ Injections ☐ Surgery

Please rate your pain on a Scale of 0 (no pain) to 10 (worst pain imaginable): ________

Do you have radiating pain? ☐ Yes No Where? ________________________________

Do you have pain at night that wakes you from sleep? Yes No __________________

How far can you walk? ☐ Unlimited or (eg. 2 blocks, 1 mile …) ________________

CURRENT AND PAST MEDICAL CONDITIONS

Please list any current or past medical conditions (e.g. high blood pressure or cholesterol, diabetes, heart condition, asthma, kidney problems, etc)

____

____

Please list your past surgeries (include year):

____

____

____

Current Medications (include dosage & frequency):

____

____

____

____

Do you have any family history (in siblings or parents) of specific medical problems or illnesses? (e.g. heart attack, stroke, cancer, diabetes, other)

____

Who lives at home with you?

☐ Live alone ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Siblings ☐ Pets

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

Do you have any children? ☐ No ☐ Yes (how many?) ______

HABITS

Alcohol: ☐ Never ☐ Occasionally ☐ Daily (____ drinks per day)

Tobacco: ☐ Never ☐ Quit (___ years ago) ☐ Daily (____ packs per day)

ALLERGIES TO MEDICATIONS

Do you have any known allergies?

☐ No

☐ Yes (please list medications to which you're allergic in the line below)

Have you or anyone in your family ever had problems with anesthesia?

☐ No

☐ Yes

Patient Name: ______________________________________ MRN: ___________ Date: ____________

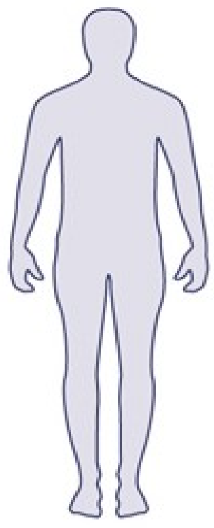
Pain Diagram

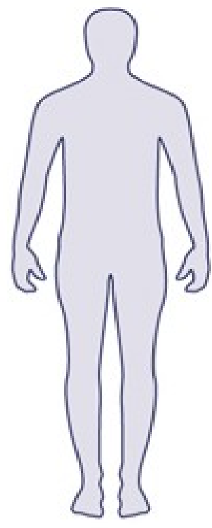
Circle the number that describes the severity of your pain:

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

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

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





Review of Systems

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

Constitutional — *Physician Comments*
- ☐ Fevers/ Chills/ Sweats ________
- ☐ Unexplained weight gain/ loss ________
- ☐ Excessive thirst or urination ________

Respiratory
- ☐ Cough/ Wheeze ________
- ☐ Difficulty breathing ________

Neurologic
- ☐ Headaches ________
- ☐ Dizziness/ Light Headedness
- ☐ Numbness ________
- ☐ Loss of Coordination ________

Skin/ Integument
- ☐ Eczema ________
- ☐ Rash ________

Hematologic/ Lymphatic
- ☐ Excessive Bleeding ________
- ☐ Easy Bruising ________

Endocrine
- ☐ Diabetes ________

Cardiovascular — *Physician Comments*
- ☐ Chest Pain ________
- ☐ Palpitations ________

Gastrointestinal
- ☐ Blood in bowels ________
- ☐ Abdominal pain ________
- ☐ Nausea/ Vomiting ________
- ☐ Diarrhea ________

Mental Health
- ☐ Anxiety/ Stress ________
- ☐ Trouble Sleeping ________
- ☐ Depression ________

Genitourinary
- ☐ Incontinence ________
- ☐ Retention ________
- ☐ Recurrent UTI ________

Rheumatologic
- ☐ Rheumatoid arthritis ________

Other/ Not Listed: ______________________
- ☐ None Apply/ No Symptoms

Physician Signature: ____________________ Date: ___________

I have reviewed and discussed this with the patient.