PENINSULA
BONE AND JOINT CLINIC

NEW PATIENT INFORMATION

DR. ROBERT DETCH
ORTHOPEDIC SURGEON

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 | Prefered 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)

1

2

Allergies to Medications:

1

2

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

Alcohol? ◯ Never ◯ Occasionaly ◯ 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:

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PAIN DIAGRAM

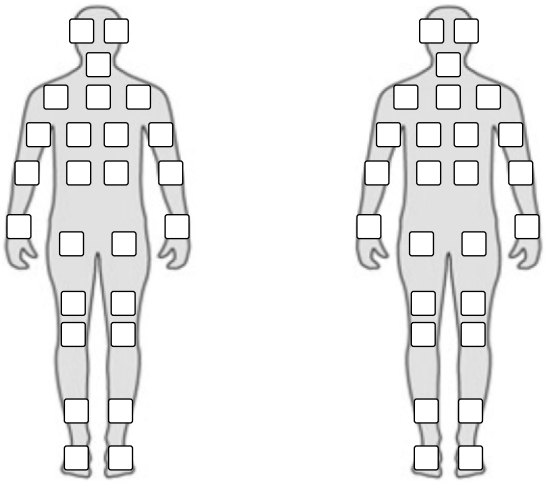
Patient Name: _____ Date: _____

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)

	Physician Comments
Constitutional	
☐ 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	

	Physician Comments
Cardiovascular	
☐ 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.