PENINSULA
BONE AND JOINT CLINIC

NEW PATIENT INFORMATION

DR. PAUL ABEYTA
ORTHOPEDIC SURGEON

Today's Date:
Preferred Name:
Last Name:
Age: Height: Weight:
Who referred you to this office?
Primary Care Physician:
Currently working? ☐ YES ☐ NO Occupation:

What is your reason for visit today?

When did this start?

Was there an accident or activity that started this? If so, please state:

Does it wake you up at night? ☐ YES ☐ NO What is your pain at its worse (scale 0-10)?

What symptoms are you having? (Please Select):

☐ Pain ☐ Stiffness ☐ Weakness ☐ Cracking/Popping ☐ Giving out ☐ Instability
☐ Difficulty sleeping ☐ Numbness ☐ Burning/Tingling ☐ Other:

Select the treatments you have you tried:

☐ Tylenol/Ibuprofen/Advil/Aleve ☐ Physical therapy ☐ Cortisone injections/PRP ☐ Surgery
☐ Rest/Modified Activity ☐ Massage/Chiropractor/Acupuncture ☐ Other:

What is the most important thing that you want to make sure gets accomplished today?

Please circle what you may be interested in today:

☐ Diagnosis ☐ Physical Therapy ☐ Surgical Options ☐ Non-surgical Options ☐ Injection
☐ X-Ray ☐ MRI ☐ Reassurance ☐ Other:

PERSONAL INFORMATION

What types of exercise or sports do you do? How often?
Who lives at home with you?

SURGICAL HISTORY

Please list any past orthopedic surgeries or injuries (and approximate year) that may be related to your condition today (e.g. "right shoulder surgery 2019" if you are here for shoulder pain today):

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MEDICAL HISTORY

Medications:

Allergies:

Please answer the following questions:

Do you have diabetes? ☐ NO ☐ YES – last known HbA1c? ____

Do you smoke cigarettes or vape? ☐ NO ☐ YES – how many packs a day? ____ ☐ Former Smoker

Do you drink alcohol? ☐ NO ☐ YES – how many drinks per week? ____

Do you have allergies to lidocaine or local anesthetic? ☐ NO ☐ YES

Are you on blood thinners (Eliquis, Coumadin, Xarelto, Plavix)? ☐ NO ☐ YES : ____

Have you or immediate family ever had a blood clot in the leg or lungs (DVT, pulmonary embolism)?

☐ NO ☐ NOT SURE ☐ YES – please provide details: ____

REVIEW OF SYSTEMS:

Do you have any problems with… (please check any that apply):

General	◯ Fever ◯ Chills ◯ Sweats	◯ Unexplained weight gain/loss	◯ Excessive thirst/urination
Cardiovascular	◯ Chest Pain ◯ Palpations		
Respiratory	◯ Cough/Wheeze ◯ Difficulty Breathing		
Gastrointestinal	◯ Heartburn/Reflux ◯ Stomach Ulcers	◯ Abdominal Pain	
	◯ Nausea/Vomiting ◯ Diarrhea	◯ Bloody Stools	
Genito-Urinary	◯ Incontinence ◯ Retention	◯ Recurrent UTI	
Endocrin	◯ Diabetes		
Skin	◯ Eczema ◯ Rash	◯ Allergic Dermatitis	
Hematologic	◯ Excessive Bleeding ◯ Easy Bruising	◯ Family History of Bleeding Disorders	
Neurologic	◯ Headaches ◯ Dizziness/Light Headedness	◯ Numbness ◯ Weakness	◯ Foot Drop
Rheumatologic	◯ Rheumatoid Arthritis		
Mental Health	◯ Anxiety/Stress ◯ Trouble Sleeping	◯ Depression ◯ Mania	

Do you need any of the following? ☐ School/PE Note ☐ Work Note ☐ DMV Placard*

**temporary DMV placards are issued ONLY for patients undergoing surgery*

Office use only – DO NOT write below this line

Physician Signature: _____ Date: _____

I have reviewed and discussed this with the patient.