

Orthopaedic Associates of Augusta, P.A.

Established Patient Medical History – New Problem

Patient's Name _____ Date _____

1) Please state your new problem: _____

- 2) With regard to this problem, please answer the following questions:
- a. Location (for example: low back pain) _____
 - b. Quality (for example: spasms, sharp) _____
 - c. Timing (how often?) _____
 - d. Context (what brings pain on?) _____
 - e. Modifying factors (for example: symptoms occur in rainy weather) _____

3) Please indicate if you are now having problems in any of these areas:

a. Constitutional	YES	NO
b. Eyes (for example: blindness, blurry eyesight)	YES	NO
c. Ears, Nose or Throat (for example: ringing in the ears)	YES	NO
d. Heart or Blood Vessels (for example: high blood pressure)	YES	NO
e. Lungs (for example: asthma, bronchitis)	YES	NO
f. Stomach /GI System (for example: nausea)	YES	NO
g. Urinary System (for example: burning during urination)	YES	NO
h. Muscles and joint other than listed above (ex: osteoporosis)	YES	NO
i. Skin (for example: rashes, itchy skin)	YES	NO
j. Neurological problems (ex: numbness, headaches, dizziness)	YES	NO
k. Psychological (for example: depression)	YES	NO
l. Endocrine (ex: losing weight without trying, very thirsty)	YES	NO
m. Blood Systems (ex: anemia, symptoms such as fainting)	YES	NO
n. Lymphatic (for example: swollen glands)	YES	NO

Please list any new allergies: _____

4) Has there been any CHANGE in your health status since your last visit?

NO YES (please explain) _____

5) Has there been any CHANGE in the following areas since your last exam in the office?

a. Marital Status	YES	NO						
b. Occupation	YES	NO						
c. Alcohol use	YES	NO	Tobacco use	YES	NO	Drug use	YES	NO
d. Medicines	YES	NO						
e. Females: Are you pregnant?	YES	NO	UNCERTAIN					

Primary Care Doctor: _____

Date of your last exam: _____

Alternate contact person and phone number: _____

 Patient's signature

 Physician's signature