

NEW PATIENT FORM - DR. BRADBURY

Patient Name: _____

Date: _____

Age: _____ Male Female

Primary Care Physician and Address: _____

Name & Address of Person who referred you to see us: _____

 MD Friend Patient _____




Physicians who follow you regularly (Cardiologist, etc.):

Reason for Visit: _____

Do you have pain? YES NO

If so, how long have you had this pain? (Months, Years) _____

How severe is your pain? No Pain Severe Pain

 0 1 2 3 4 5 6 7 8 9 10

Was this the result of an injury? YES NO

If Yes, Date of Injury: _____

Lawsuit Pending: YES NO

Workers' Compensation: YES NO

What makes the pain better? _____

What makes the pain worse? _____

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		No Pain					Severe Pain					
		☺					☹					
What Else	<input type="checkbox"/> Right Hip	0	1	2	3	4	5	6	7	8	9	10
Hurts?	<input type="checkbox"/> Left Hip	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> Right Knee	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> Left Knee	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> Spine	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> _____	0	1	2	3	4	5	6	7	8	9	10

Do you use any of the following:

- Cane Crutches Walker Wheelchair

How do you walk stairs?

- One leg after the other (normal)
 Lead with same leg each time

Do you need a rail to walk up/down stairs? YES NO

How far can you walk before limited by pain: _____

Can you put on your own socks and shoes? YES NO

What have you tried to help the pain?

- Ice
- Rest/Decreased activity
- Physical Therapy
- Pain Medication: Percocet Vicodin Lortab Oxycodone OxyContin
- Anti-inflammatory: Vioxx Celebrex Bextra Aspirin
 Ibuprofen Motrin Advil Alleve Naprosyn
- Glucosamine/Chondroitin Sulfate
- Injections
 - Hip Knee Spine

When was your last injection? _____

How long did your injection last? ___ Days ___ Weeks ___ Months ___ Years

How many total injections have you had? _____

- Orthotics
- Acupuncture
- Chiropractor
- Cane
- Brace
- Other _____

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Medical Problems:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Previous Surgeries: (list dates)

<input type="checkbox"/> Appendectomy _____	<input type="checkbox"/> Knee Arthroscopy _____
<input type="checkbox"/> Tonsillectomy _____	<input type="checkbox"/> Total Knee Replacement _____
<input type="checkbox"/> Hernia Repair _____	<input type="checkbox"/> Total Hip Replacement _____
<input type="checkbox"/> Gallbladder _____	_____
<input type="checkbox"/> Hysterectomy _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____

Have you ever had a surgical infection?	<input type="checkbox"/> YES	<input type="checkbox"/> NO (If yes, where? _____)
Have you ever had general anesthesia?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Problems with Anesthesia?	<input type="checkbox"/> YES	<input type="checkbox"/> NO (Problem: _____)

Current Medications: (with doses)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medications:

_____	_____
_____	_____
_____	_____

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Social History:

Occupation: _____

Working: Full Time Part Time Student

If not working, are you: Retired On Disability Unemployed

Marital Status: Single Married Divorced Separated Widowed

Number of children: _____

Who lives with you?: _____

Do you smoke tobacco? YES NO I QUIT

Number of packs per day: _____

Do you drink alcohol? YES NO I QUIT

Number of drinks per week: _____

Do you use street drugs? YES NO I QUIT

Which drugs: _____

Are you pregnant? YES NO

Family History:

Father: Alive Deceased Current age or age at time of death: _____

Medical Problems: _____

Mother: Alive Deceased Current age or age at time of death: _____

Medical Problems: _____

Brother/Sister (circle):

Alive Deceased Current age or age at time of death: _____

Medical Problems: _____

Brother/Sister (circle):

Alive Deceased Current age or age at time of death: _____

Medical Problems: _____

Brother/Sister (circle):

Alive Deceased Current age or age at time of death: _____

Medical Problems: _____

Brother/Sister (circle):

Alive Deceased Current age or age at time of death: _____

Medical Problems: _____

Other medical problems present in your extended family:

High Blood Pressure

Cancer: Breast Lung Prostate Thyroid Skin Other: _____

Heart Disease

Diabetes

Thyroid Disease

Anesthesia Complications

Other: _____

Have you ever had or experienced:

- Vision/Eye Problems
- Glaucoma
- Skin Rash
- Migraine Headaches
- Hearing Loss
- Epilepsy/Seizures
- Asthma
- COPD
- Emphysema
- Dizziness
- Shortness of Breath
- Blood Clots in Legs
- Peptic Ulcer Disease
- Hiatal Hernia
- Diverticulitis
- Gallbladder Disease
- Tuberculosis
- Pneumonia
- Heart Attack

- Heart Murmur
- Irregular Heart Beat
- Heart Surgery
- High Blood Pressure
- Diabetes
- Stroke/TIA
- Vascular Disease
- Weight Loss
- Fevers/Chills
- Swelling of
- Feet/Ankles
- Blood in Stool
- Vomiting of Blood
- Kidney Stones
- Kidney Failure/Dialysis
- Blood in Urine
- Recurrent Bladder
- Infections
- Anxiety

- Depression
- Psychiatric Problems
- Gout
- Numbness
- Cancer
 - Breast
 - Lung
 - Prostate
 - Thyroid
 - Skin
 - Other: _____
- Bleeding Disorder
- AIDS
- Arthritis
 - Hip
 - Knee
 - Lumbar Spine
 - Cervical Spine
 - Other: _____
- Thyroid Disease
 - Hypothyroidism
 - Hyperthyroidism