

New Patient / New Problem FORM**Dr. Cummings**

Name: _____ Date: _____

Age: ____ Birthdate: ____ / ____ / ____ Occupation: _____

Current work status:☐ Regular duty ☐ Light Duty ☐ Not working due to problem ☐ Retired ☐ Student ☐ Unemployed

Who referred you to us? _____

Primary Medical Doctor: _____ Primary Doctor Phone: _____

Primary Doctor's Address: _____

List any other doctors you see on a regular basis (Cardiology, Pulmonology, Neurology, Rheumatology, etc.)

_____**Do you have an Advanced Care Plan (Such as a Living Will)?** ☐ Yes ☐ No**Please explain your problem in one sentence** _____
_____**Location of symptoms** ☐ Left ☐ Right ☐ Both**When did symptoms start?** DATE (if known) _____ OR (Days____) (Weeks____) (Months____) (Years____)**What are your expectations today?**☐ Explanation or Diagnosis ☐ Tests ☐ Medicines ☐ Therapy ☐ Injection ☐ Surgery☐ Other: _____Have you had **Medical treatment/tests** for this condition in the past? ☐ Yes ☐ NoIf Yes, what **Doctor** treated you for this condition and what was done? _____
_____☐ X-Rays? Where? _____ ☐ MRI? Where? _____ ☐ CT Scan? Where? _____**How did your problem start?** (Check the **ONE** that best describes how your problem started):☐ NO INJURY- onset was ☐ Gradual ☐ Sudden Why do you think it started? _____☐ INJURY ☐ Accident ☐ Sport Date of injury _____ Sport? _____☐ WORK RELATED Date of Injury/Pain _____ How? _____☐ Worker's Comp ☐ Yes ☐ No☐ AUTO ACCIDENT Date _____**Attorney involved with this problem?** ☐ Yes ☐ No**Pain Severity:** On a scale of 0-10 (0=none; 10=worst imaginable pain) how severe is your pain? (**Circle one**)

0 1 2 3 4 5 6 7 8 9 10

Since your problem started, it is: ☐ Better ☐ Worse ☐ Unchanged ☐ Intermittent

Pain Frequency: ☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Quality of Pain: (Check all that apply)

- | | | |
|-----------------------------------|-------------------------------------|---------------------------------------|
| ☐ Aching | ☐ Electric | ☐ Shooting |
| ☐ Annoying | ☐ Irritating | ☐ Stabbing |
| ☐ Burning | ☐ Piercing | ☐ Throbbing |
| ☐ Dull | ☐ Sharp | ☐ Other: _____ |

What make your symptoms worse? (Check all that apply)

- | | | |
|--|--|---------------------------------------|
| ☐ Bending | ☐ Movement | ☐ Sitting |
| ☐ Climbing Stairs | ☐ Overhead Activity | ☐ Standing Up |
| ☐ Descending Stairs | ☐ Pushing | ☐ Squatting |
| ☐ Dressing | ☐ Prolonged Standing | ☐ Twisting |
| ☐ Exercises | ☐ Putting on Socks or Shoes | ☐ Walking |
| ☐ Kneeling | ☐ Reaching | ☐ Other: _____ |
| ☐ Lifting | ☐ Sleeping | |

How long can you walk before you need to take a break?

- | | |
|---|---|
| ☐ Unlimited | ☐ 5 to 10 minutes |
| ☐ More than 20 minutes | ☐ I just walk around the house |
| ☐ 10 to 20 minutes | ☐ I cannot walk |

What limits your walking?

- ☐ No Limit ☐ This problem ☐ Another problem _____

Associated Symptoms: (Check all that apply)

- | | | |
|---|--------------------------------------|---|
| ☐ Bruising | ☐ Instability | ☐ Swelling |
| ☐ Catching | ☐ Limping | ☐ Tingling |
| ☐ Clicking | ☐ Locking | ☐ Weakness |
| ☐ Decreased Mobility | ☐ Numbness | ☐ Waking up at Night |
| ☐ Fever | ☐ Popping | ☐ Other _____ |
| ☐ Giving Way | ☐ Spasms | ☐ Other _____ |

Previous Treatments for this problem: (Check all that apply)

- | | | |
|--|---|---|
| ☐ Acupuncture | ☐ Exercise(_____) | ☐ Rest |
| ☐ Advil _____ mg / day | ☐ "Gel" Injection | ☐ Stretching |
| ☐ Aleve _____ mg / day | (Euflexxa, Synvisc, etc.) | ☐ Tramadol |
| ☐ Brace/Splint | ☐ Heat | ☐ Tylenol _____ mg / day |
| ☐ Cane | ☐ Ice | ☐ Vicodin |
| ☐ Cream (_____) | ☐ Massage | ☐ Walker |
| ☐ Cortisone Injection | ☐ Percocet | ☐ Other _____ |
| ☐ Elevation | ☐ Physical Therapy | _____ |
| ☐ Other Medications (for this problem): _____ | | |

SURGICAL/PROCEDURE HISTORY: Check if **you** have had any of the following, indicate approximate **DATE**:

- | | |
|---|---|
| ☐ Appendix Removed _____ | ☐ Orthopedic Surgery (<i>Specify</i>): _____ |
| ☐ Breast Surgery(<i>Specify</i>) _____ | _____ |
| ☐ Cataract Surgery _____ | _____ |
| ☐ Cardiac Pacemaker or Defibrillator _____ | ☐ Prostate Procedure (<i>Specify</i>): _____ |
| ☐ Colon Surgery _____ | ☐ Spine Surgery (<i>Specify</i>): _____ |
| ☐ Gall Bladder Removed _____ | ☐ Spleen Removed _____ |
| ☐ Gastric (Stomach) Procedure _____ | ☐ Stents _____ |
| ☐ Hysterectomy _____ | ☐ Transplant (<i>Specify</i>): _____ |
| ☐ Inferior Vena Cava (IVC) Filter _____ | ☐ Other _____ |
| ☐ Open Heart Surgery _____ | _____ |

Past hospitalizations/injuries and approximate dates: _____

MEDICAL HISTORY: Please check if **you** have ever been diagnosed with any of the following:

- | | |
|---|--|
| ☐ Acid Reflux (GERD) | ☐ Kidney Stones |
| ☐ Alcoholism | ☐ Osteoarthritis |
| ☐ Anxiety | ☐ Osteopenia |
| ☐ Asthma | ☐ Osteoporosis |
| ☐ Atrial Fibrillation (AFib) | ☐ Parkinson's Disease |
| ☐ Bleeding problems _____ | ☐ Pneumonia. When? _____ |
| ☐ Cancer: Type/Treatment: _____ | ☐ Previous Heart Attack. When? _____ |
| _____ | ☐ Prostate Problem _____ |
| ☐ COPD/Chronic Bronchitis/Emphysema | ☐ Psychiatric illness _____ |
| ☐ Coronary Artery Disease (Heart Disease) | ☐ Rheumatoid Arthritis |
| ☐ Crohn's disease | ☐ Sleep Apnea. Use CPAP? ☐ Yes ☐ No |
| ☐ Depression | ☐ Spinal Stenosis |
| ☐ Diabetes | ☐ Stroke or TIA. Residual deficit? _____ |
| ☐ Fibromyalgia | ☐ Substance Abuse _____ |
| ☐ Glaucoma | ☐ Thyroid Disease |
| ☐ Gout | ☐ Tuberculosis |
| ☐ Hiatal Hernia | ☐ Ulcers |
| ☐ HIV | ☐ Ulcerative Colitis |
| ☐ High blood pressure | ☐ Vascular disease |
| ☐ High cholesterol | ☐ Other: _____ |
| ☐ Heart disease | _____ |
| ☐ Hepatitis ☐ A ☐ B ☐ C | _____ |
| ☐ Hemophilia | _____ |
| ☐ Kidney Disease _____ | _____ |

Have you ever had a **Blood Clot**? ☐ Yes ☐ No

If yes Explain: _____

Have you ever had a **serious infection** requiring IV antibiotics? ☐ Yes ☐ No

If Yes, Explain: _____

SOCIAL HISTORY:

Marital status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Do you live alone? ☐ Yes ☐ No **Who do you live with?** _____

Do you use a device to help move about? ☐ Yes ☐ No

If so: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Tobacco use: ☐ Never

☐ Quit When? _____ Years smoked: _____ Packs smoked per day _____

☐ Current Smoker: Packs per day ☐ <1/2 ☐ 1/2 ☐ 1 ☐ 1 1/2 ☐ 2 _____ packs

Years Smoked: _____ years

Alcohol use: ☐ Never ☐ Rarely ☐ 1-2 drinks/week ☐ _____ drinks/week ☐ _____ drinks per day

Recreational Drug use: ☐ Never ☐ Marijuana ☐ Cocaine ☐ Other: _____

FAMILY HISTORY: Please check if any of your **relatives** ever had any of the following problems- indicate who:

- | | | | |
|--|------------|---|------------|
| ☐ Alcoholism | Who: _____ | ☐ Rheumatoid Arthritis | Who: _____ |
| ☐ Heart disease | Who: _____ | ☐ High blood pressure | Who: _____ |
| ☐ Bleeding disorder | Who: _____ | ☐ Blood Clot | Who: _____ |
| ☐ Diabetes | Who: _____ | ☐ Stroke | Who: _____ |
| ☐ Cancer | Who: _____ | ☐ Thyroid disease | Who: _____ |
| ☐ Other: _____ | | | |

Height _____ / _____ Weight _____

(Patients seen by other **TPMG** doctors do not need to fill out the Allergy or Medication sections)

ALLERGIES to MEDICATIONS: Please check med and **LIST REACTION** (hives, anaphylaxis, nausea, etc.)

☐ Cephalosporins _____	☐ Sulfa _____	☐ Other _____
☐ Clindamycin _____	☐ NSAIDs _____	_____
☐ Latex _____	☐ IV contrast Dye _____	_____
☐ Penicillin _____	☐ Vancomycin _____	_____

CURRENT MEDICATIONS (include **DOSAGE** and **# times taken/day**) and **HERBAL/ALTERNATIVE** supplements including **VITAMINS**. (Alternatively, provide a separate list and attach to this form)

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

REVIEW OF SYSTEMS (Check all that apply to you)

Constitutional

- ☐ Good General Health
- ☐ Recent weight loss/gain
- ☐ Night sweats, fevers
- ☐ Fatigue

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ Swelling Legs

Musculoskeletal

- ☐ Muscle pain or cramps
- ☐ Stiffness/swelling in joints
- ☐ Joint pain
- ☐ Trouble walking

Endocrine

- ☐ Cold Intolerant
- ☐ Hair Loss
- ☐ Heat Intolerant

Psychiatric

- ☐ Depression
- ☐ Insomnia
- ☐ Anxiety

Ears/Nose/Mouth/Throat

- ☐ Hearing loss or ringing
- ☐ Sinus problems
- ☐ Vertigo
- ☐ Headaches

Respiratory

- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing/asthma
- ☐ Known TB Exposure

Neurological

- ☐ Memory Loss
- ☐ Paralysis or tremors
- ☐ Convulsions/seizures
- ☐ Difficulty Walking

Hematologic/Lymphatic

- ☐ Bruise easily
- ☐ Slow to heal
- ☐ Bleeding

Genitourinary

- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence

Eyes

- ☐ Wear glasses/contacts
- ☐ Blurred/double vision
- ☐ Vision Loss

Gastrointestinal

- ☐ Nausea/vomiting
- ☐ Abdominal Pain
- ☐ Loss of Appetite
- ☐ Diarrhea

Integumentary (Skin)

- ☐ Lesion
- ☐ Rashes or itching
- ☐ Infection

Allergic/Immunologic

- ☐ Food allergies
- ☐ Aspirin allergies
- ☐ Antibiotic allergies

Patient Statement: To the best of my knowledge, the above information is accurate.

Patient's Signature: _____ Date: _____