New Patient Information

Dr. Todd Kim, Orthopedic Surgery

Preferred Patient Name: _____

Last Name: _____

Pronouns (e.g. , he, she, they): _____

Today's Date: _____

GENERAL INFORMATION

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?**

☐ Right ☐ Left _____ _____

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

Is this recurrent or has this happened before? If so, please explain: _____

Does it cause you difficulty sleeping? ☐ YES ☐ NO What is your pain at its worse (scale 0-10)? ____

What symptoms are you having? (Please circle):

Pain Stiffness Weakness Cracking/Popping Giving out

Instability Numbness Burning/Tingling Other: _____

What treatments have you tried for this issue (physical therapy, injections, surgery, tylenol, ibuprofen)?

_____ _____ _____ _____

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? _____ Are you: ☐ Right handed ☐ Left handed ☐ Both

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MEDICAL 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):

_____ _____ _____ _____

_____ _____ _____ _____

Please answer the following questions:

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

Do you smoke cigarettes? ☐ YES – how many packs per day? _____ ☐ NO ☐ Former Smoker

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

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

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

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

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

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
Endocrine	☐ 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

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Physician Signature: _____ Date: _____

I have reviewed and discussed this with the patient.