Livingston HealthCare
Billings Clinic Affiliate

ORTHOPEDIC SURGERY
New Patient Form

Name:______________________________ Physician:______________________________

DOB:__________________ Age:______________ Date of Visit:______________________________

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Chief Complaint: *(Reason for visit)*

When and how did the problem start? *(Give dates and description)*

Location of Problem: *(Body areas affected)*

Describe Symptoms: *(Types of Pain – Sharp / Dull / Aches / Throbbing, etc)*

Describe the Severity: (*Mild / Moderate / Severe / Disabling, etc)*

Duration of Symptoms: *(Intermittent / Constant / Number of Minutes, etc)*

Timing of Symptoms: (*After exercise / at night / with typing, etc)*

Associated Symptoms: *(Bruising / Numbness / Tingling / Swelling / Tenderness / Sensitivity to heat/cold / Discoloration, etc)*

What Makes the Problem Better: *(Rest / Heat / Cold / Meds / Elevation / Compression, etc)*

What Makes the Problem Worse:

Course of the Problem: *(Getting Worse / Better / No Change)*

How Bad is the Pain Now? *(Circle)* 0 = Pain Free 10 = Worst Pain

0 1 2 3 4 5 6 7 8 9 10 (*Location*)____________________

0 1 2 3 4 5 6 7 8 9 10 ____________________

0 1 2 3 4 5 6 7 8 9 10 ____________________

0 1 2 3 4 5 6 7 8 9 10 ____________________

Past Medical History (Check all that apply)

○ High Blood Pressure	○ Pneumonia	○ Cancer (type)__________
○ Heart Disease	○ Thyroid	○ Depression
○ Asthma	○ Arthritis	○ Drug/Alcohol Abuse
○ Diabetes	○ Stroke	○ Epilepsy/Seizures
○ Kidney Disease	○ Bleeding Disorder	○ Hay Fever
○ Liver Disease	○ Immune Disease	○ Tuberculosis (TB)
○ Hepatitis	○ Anemia	○ Stomach Ulcers

Previous Surgeries (If NOT performed at LHC): *(Include Dates)*

Medications (If NOT LHC patient): *(specify dosage and include over-the-counter drugs)*

Allergies (If NOT LHC patient): *(Medications / Food / Latex / Environment – Describe Reaction)*

Past Family Medical History:

	Age	Medical Problems	If deceased, Cause of Death
Father			
Mother			
Siblings			

Smoking: *(Packs per Day / Number of Years)*

Alcohol: *(Number of Drinks per Week)*

Do you Eat a Balanced Diet?	☐ Yes	☐ No	Birthplace:
Is Your Weight Stable?	☐ Yes	☐ No	Current Residence (Town):

Who Currently Lives at Home with You?

Indicate Any Other important Information the Doctor Should Know:

Please Check If You Presently Have Any Problems or Symptoms in the Following Areas:

Constitutional
- ○ Fever
- ○ Chills
- ○ Night Sweats
- ○ Weakness
- ○ Fatigue
- ○ Decreased Activity

Head-Related Symptoms
- ○ Headache
- ○ Facial Pain
- ○ Sinus Pain

Eye Symptoms
- ○ Recent Visual Problems
- ○ Icterus
- ○ Blurring
- ○ Double Vision

Ear / Nose / Throat Symptoms
- ○ Nasal Congestion
- ○ Sore Throat
- ○ Decreased Hearing
- ○ Ear Pain
- ○ Other

Integumentary
- ○ Skin Lesion
- ○ Hypertrophic scar

Respiratory
- ○ Short of Breath
- ○ Cough
- ○ Wheezing
- ○ Hemoptysis

Cardiovascular
- ○ Palpitations
- ○ Bradycardia
- ○ Tachycardia
- ○ Peripheral Edema
- ○ Syncope

Genitourinary Symptoms
- ○ Dysuria/Hematuria
- ○ Change in Urine Stream
- ○ Urethra Discharge

Gastrointestinal Symptoms
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Heartburn
- ○ Hematemesis
- ○ Abdominal Pain

Gynecologic (for Women)
- ○ Hot Flashes
- ○ Intermenstrual Bleeding

Heme/Lymph/Endocrine
- ○ Easy bruising/bleeding
- ○ Swollen Lymph Glands
- ○ Excessive Thirst
- ○ Polyuria
- ○ Cold Intolerance
- ○ Heat Intolerance
- ○ Excessive Hunger

Immunologic
- ○ Immunocompromised
- ○ Recurrent Fevers
- ○ Recurrent Infections

Neurologic Symptoms
- ○ Alert and Oriented
- ○ Abnormal Balance
- ○ Confusion
- ○ Numbness/Tingling

Psychological Symptoms
- ○ Anxiety
- ○ Depression
- ○ Mania
- ○ Delusional
- ○ Hallucinations

Please Explain Checked Items:

Patient Signature:**____** ***Date:*****________________________**

Relationship *(If other than Patient):*________________________________

Patient Label Here