Quality Orthopedics & Complete Joint Care, P.C.

First-Time Office Visit

YOUR BASIC INFORMATION:

Name:_____ Age: _____ Date of Birth: _____

Primary care doctor:_____ Today's Date:_____

Did anyone refer you to us? O No O Yes, my primary care doctor Height: _____

O Someone else [Please list:_____] Weight: _____

REASON YOU ARE HERE TODAY:

What is the problem or injury?_____

When did the problem start?_____How severe is the pain? (1-10 scale) _____

Is this a work-related injury? O Yes O No Is this injury from a motor vehicle accident? O Yes O No

ALLERGIES: O **NONE** O Latex O Penicillin O Aspirin O Iodine O Shellfish O Other:_____

MEDICATIONS YOU TAKE: _____

_____

OPERATIONS/SURGERY YOU HAVE HAD: _____

_____

MEDICAL HISTORY: (Check any health problems that you have or have had, write any that are not listed)

O Bleeding problems	O Kidney	O Arthritis	O Asthma
O Anemia	O Liver disease	O Gout	O Diabetes
O High blood pressure	O Hepatitis [O O O C]	O Parkinson's	O HIV or AIDS
O Heart disease/heart attack	O Colitis	O Stroke/TIA	O High
O Atrial Fibrillation	O Diverticulitis	O Seizures	O Other:
O Pacemaker	O Ulcers/GERD	O Phlebitis/DVT (blood	
O Lung disease	O Thyroid problems	O Venereal disease	

O COPD/emphysema O Lupus O Cancer [Type:_____]

HOW ARE YOU FEELING TODAY?: (Check any symptoms that you have today, write any that are not listed)

O Weight gain	O Chest pain	O Joint pain	O Urinary infections
O Weight loss	O Shortness of breath	O Weakness	O Rashes
O Headaches	O Palpitations	O Paralysis	O Lumps
O Blackouts	O Cough	O Low back pain	
O Dizziness	O Abdominal pain	O Painful urination	O Other:
O Double vision	O Bloody stool	O Bloody urine	_____

MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY:

O Diabetes O Heart disease O High blood pressure O Arthritis O Other: _____

PERSONAL HISTORY:

What kind of work do you do?_____ O Retired O Disability O Unemployed

Marital status: O Single O Married O Divorced O Widowed

Living situation: O Alone O w/Spouse O w/Family O w/Significant other O Other

Smoking: O Most/every day O Some days O Former smoker O Never smoked

If yes, how much?_____ For how many years?_____

Do you drink any alcohol? O Never O Occasional O Frequent

Do you use any other drugs? O None O _____

Aleksandr Khaimov, D.O

Reviewing Physician Print Name	Signature/Credentials	Date/Time