**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 disease |  |  | O Arthritis | O Asthma |
| O Anemia | O Liver disease |  |  | O Gout | O Diabetes |
| O High blood pressure | O Hepatitis [O A | O B | O C] | O Parkinson’s | O HIV or AIDS |
| O Heart disease/heart attack | O Colitis |  |  | O Stroke/TIA | O High Cholesterol |
| O Atrial Fibrillation | O Diverticulitis |  |  | O Seizures | O Other: |
| O Pacemaker | O Ulcers/GERD | O Phlebitis/DVT (blood clot) |   |
| 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