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PATIENT STICKER

NEW PATIENT INFORMATION SHEET

(Please print)

1. Referring Physician: Name:

   Address:

   Phone:

2. Chief Complaint (what problem brings you in today?):

3. History of your Main Complaint:

4. Previous Treatment: (Circle: Surgery, Physical Therapy, Injection, Brace, Other_____)?

5. Past Medical History (Any medical problems?):

6. Past Surgical History (Any surgery in the past?):

7. Current Medications: Allergies:

8. Social History:

   - Do you smoke? ❑❑Yes ❑❑No
   - Do you drink alcohol? ❑❑Yes ❑❑No

If yes, how much per day?

If yes, how much per day?

- Occupation
- Marital Status

Children?

9. Family History of Medical Problems: If yes, explain

- Father: ❑❑Yes ❑❑No
- Mother: ❑❑Yes ❑❑No
- Grandparents: ❑❑Yes ❑❑No
- Siblings: ❑❑Yes ❑❑No

10. Any Medical Problems in the following areas?	Yes	No	If yes, explain
Constitutional symptoms: fever, weight loss, fatigue	❑❑	❑❑	
GI problems	❑❑	❑❑	
Eyes	❑❑	❑❑	
Ears, nose, throat	❑❑	❑❑	
Heart, circulation	❑❑	❑❑	
Bladder	❑❑	❑❑	
Breathing, lungs, shortness of breath	❑❑	❑❑	
Other miscellaneous problems	❑❑	❑❑	
Skin	❑❑	❑❑	
Nerves, coordination, neurological	❑❑	❑❑	
Psychological	❑❑	❑❑	
Endocrine	❑❑	❑❑	
Blood, lymphatics	❑❑	❑❑	
Immune problems	❑❑	❑❑	
Menstrual problems	❑❑	❑❑	

Seth C. Gamradt, MD_____