PASADENA ORTHOPEDICS

New Patient Form

Preferred Name: _____

Recreational/Exercise Activities - _____

Reason For Visit (in your own words): _____

Date of Injury or Duration of Symptoms: _____

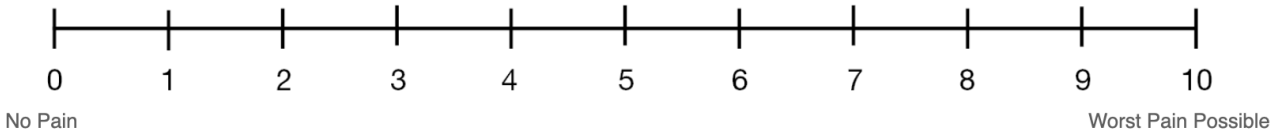
How did this start? If there was an injury, what happened?: _____

Symptoms other than pain: _____

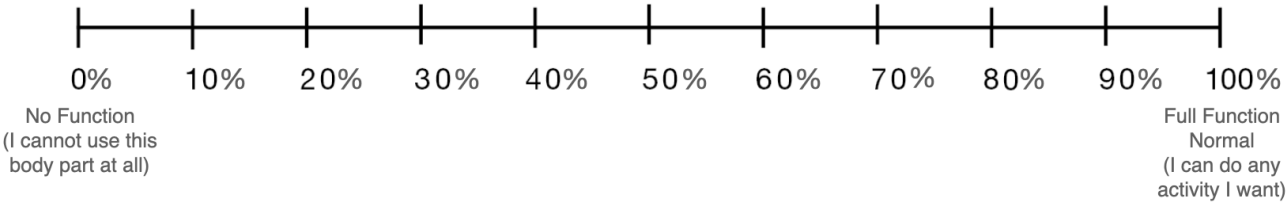
Please mark an "X" along the line to indicate your answer to the following questions:

How would you rate your pain right now?

How would you rate your pain at its worst?



How would you rate the function of your affected body part as a percentage of normal?



Prior Treatments for This Problem (please include dates where applicable):

[ ] - *Surgery* -_____

[ ] - *Medication*(s) - _____

[ ] - *Physical Therapy* - _____

[ ] - *Injection(s)* - _____

[ ] - *Braces/Equipment* - _____

[ ] - *Other* - _____

Have you ever experienced:

[ ] A Blood Clot

[ ] A Bleeding Problem

[ ] A Stroke

[ ] An Infection Requiring Surgery or IV Antibiotics

[ ] Anesthesia Complications

[ ] Heart Problems Requiring Further Tests

[ ] Lung Problems Requiring Further Tests

[ ] Kidney or Liver Problems Requiring Further Tests

Do you use tobacco products? [ ] Yes [ ] No [ ] I did previously, but quit

What are your goals for this visit? _____

_____

_____

Anything else you would like us to know? _____

_____

_____