NEW PATIENT MEDICAL HISTORY
FOR JOSEPH R. RITCHIE, M.D.

Thank you for taking the time to fill out this form. Please fill in all the sections to the best of your ability before your appointment. The information you provide greatly enhances our ability to give you the best care possible. *(PLEASE PRINT)*

Name _____ Today's Date _____

Date of Birth: _____ Height: _____ Weight: _____

1) Who referred you to this office? _____
Address _____

We will prepare a typed report of your visit and examination. A copy of the report is automatically sent to your referring physician. If this is a Worker's Compensation claim, a copy of the report will automatically be sent to your employer/insurance carrier by law.

Please provide the name and address of any other health care provider to whom you would like us to send a copy of your report.

_____
_____
_____

2) What is your chief problem at this time? Right / Left _____
_____

3) When does the problem occur? _____

4) How long has the problem been present? _____

5) Did you have an injury? Yes _____ No _____ (if no, please go to question 7)
Date of injury: ___/___/___ Where did the injury occur? _____at work _____sport _____other
How did the injury occur? _____
_____
How was the injury treated? _____
Who treated you? _____
Results of treatment: _____

6) Have you had a previous injury or work related injury to this same area? Yes _____ No _____
-Date of previous injury: ___/___/___ -How did it occur? _____
-Residual symptoms: _____

7) Occupation: _____
Current Work Status: ____ Regular Duty ____ Light Duty ____ Off Duty
If not working, it is because: ____ Retired ____ Medical Leave ____ Laid Off
Employer: _____ How long have you been at this job? _____

8) How much time have you missed from work? _____

9) Is this a work-related injury? Yes_____ No_____

10) **Is an Attorney working on your problem? Yes_____ No_____**

11) **For THIS problem, have you had any of the following?**

	When?	Where?
X-rays		
MRI		
Nerve Studies		
CT Scan		
Bone Scan		

ALLERGIES TO MEDICATIONS?

PLEASE LIST:

Metals/Jewelry:

LATEX ALLERGY? YES / NO

MEDICATIONS FOR CURRENT PROBLEM	Dose
OTHER MEDICATIONS	

HOSPITALIZATIONS and SURGERIES	
Surgery	Date
Past Surgery on Current problem area? Yes/No	
Other Past Surgeries:	

Social History:

Are you married Yes / No
Number of years _____
Do you have children Yes / No
Number _____
Do you live with someone who can help you?
Yes / No
Do you smoke? Yes / No
Packs per day? _____
Do you drink alcohol? Yes / No
Drinks per week? _____
Any history of drug or alcohol abuse? Yes/No

Family History (*Check those that apply*)

	Self	Mom	Dad	Sibling
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐

YOUR HEALTH HISTORY

(PLEASE CIRCLE all that apply)

HAVE YOU EVER HAD A BLOOD CLOT? _____ Yes _____ No

CHILDHOOD HISTORY - NONE

Scarlet Fever	Rubella	Rheumatic Fever	Polio
Mumps	Diphtheria	Measles	Tetanus

CONSTITUTIONAL - NONE

Fever	Chills	Weight Loss

EAR, NOSE, THROAT - NONE

Dizziness	Cold Sore	Sinus Problems	Ear Problems
Deafness	Motion Sickness		

CARDIOVASCULAR - NONE

Palpitations	Chest Pains	Heart Murmur	High Blood Pressure
High Cholesterol	Vascular Disease	Pacemaker	Stents

Are you currently under the care of a cardiologist? Yes/No

RESPIRATORY - NONE

Asthma	Bronchitis	Emphysema	Pneumonia
Shortness of Breath			

GASTROINTESTINAL - NONE

Ulcer	Hepatitis	Blood in Stool	Diarrhea Black Stool
Gall Bladder Problems			

GENITOURINARY - NONE

Prostate Disease	Frequent Urination	Painful Urination	Blood in Urine

MUSCULOSKELETAL - NONE

Arthritis	Joint Pains	Gout	Rheumatoid Arthritis

ENDOCRINE - NONE

Diabetes	Thyroid Disease

NEUROLOGIC - NONE

Headaches	Migraines	Strokes	Seizures

PSYCHIATRIC - NONE

Depression	Nervousness	Anxiety

HEMATOLOGIC/LYMPHATIC - NONE

Bleeding Problems	Anemia	Easy bruising

SKIN - NONE

Rashes	Itching

INFECTIOUS DISEASE - NONE

Hepatitis	HIV

A FEW MORE IMPORTANT QUESTIONS:

1. Aside from your current problem, how would you describe your general state of health?
   _____ Good _____ Fair _____ Poor

2. Do you feel your problem is changing who you are as a person? If so, how?
   _____

3. Do you feel that you are under a lot of stress? If so, is it from this problem and why?
   _____

4. Do you already have a diagnosis for your current problem? If so, what is it?
   _____

5. What does your problem prevent you from doing (work, hobbies, sports, having a good quality of life, etc.)?
   _____

6. Do you feel that your problem is severe enough to consider surgery as an option?
   _____

7. Do you think that you need surgery?
   _____

8. What is your main goal for your office visit?
   _____

9. Is there anything you think your doctor needs to know that you have not answered in this questionnaire already?
   _____

10. Do you have any specific questions about your problem you would like your doctor to answer? Please list them:
    _____
    _____
    _____
    _____

I HAVE COMPLETED ALL THE QUESTIONS IN THIS FORM TRUTHFULLY, COMPLETELY AND TO THE BEST OF MY KNOWLEDGE. THERE WILL BE A $ 20.00 CHARGE FOR ALL FORMS FILLED OUT SUCH AS FMLA OR DISABILITY.

_____ _____

Patient or Guardian's Signature Date

Pain Level Shortly After the Injury

- Circle the number on the line below that represents your pan at its least.
- Circle the number on the line below that represents your pain at its worst.
- Place an "X" on the line below that represented your pain **shortly after the injury.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Severe Excruciating

Pain Level Today

- Circle the number on the line below that represents your pan at its least.
- Circle the number on the line below that represents your pain at its worst.
- Place an "X" on the line below that represented your pain **right now.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Severe Excruciating