

New Patient Information Form

Name _____ Date _____

How did you hear about Dr. Sanjay Sharma? _____

Primary Care Physician _____

Address _____ Zip Code _____

Phone _____ Fax _____

Referring Physician _____

Address _____ Zip Code _____

Phone _____ Fax _____

Please circle answers.

Are you **Right** or **Left** Handed?

Is this a work related problem? **Yes** **No** If yes, list your TWCC# _____

Employer: _____

If disabled, when did you last work? _____

Do you have a **lawyer** involved with this problem? **Yes** **No**
If yes, then who? _____

Please describe the problem that brings you here today:

1. **Where** is the problem located? **Right, Left** or **Both** (please be specific) _____

2. **When and How** did this problem begin? _____
(date of injury) _____

3. Circle the **symptom(s)** that best describes your problem:
Stiffness Pain Instability Numbness Swelling Other _____

4. If you have pain, please circle the **description** that is most appropriate:
Sharp Throbbing Aching Burning Stabbing Heavy Dull

5. Circle the number corresponding to the **intensity** of your pain or other symptoms:
(if 1 is no pain and 10 is the worst pain imaginable) **1 2 3 4 5 6 7 8 9 10**

6. Circle all that apply: Is your pain getting Better? Better Gradually, Better Rapidly
getting Worse? Worse Gradually, Worse Rapidly

7. **What** improves your symptoms? _____

8. **What** makes your symptoms worse? _____

9. Have you had **previous surgery** for this problem? **Yes** **No**
If yes, please describe: (Include when, where, the surgeon, and was surgery beneficial?)

10. **What studies** have you had for this problem? (circle all that apply)
X-rays CT MRI Nerve study(EMG) Arthrogram Bone Scan

11. Do you have any **allergies**? **Yes** **No** If so, please list.
To medications? _____

To foods? _____
Are you allergic to **latex**? **Yes** **No** Are you allergic to **iodine**? **Yes** **No**

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Please list **all medications** you now take. Include dose and frequency:

Please list **all surgeries** you have had.

Do you have any of the following **medical problems?**

	No	Yes	Comments
General (weight gain/loss, fatigue, insomnia)			
Vision (glasses/contacts, cataracts, glaucoma)			
Ear/nose/throat (sinus trouble, hearing loss, ringing)			
Cardiac (irregular heartbeat, high blood pressure chest pain, fluttering in chest)			
Pulmonary (shortness of breath, lung disease, persistent cough)			
Gastrointestinal (decreased appetite, constipation, heartburn nausea, diarrhea, hepatitis A, B, C)			
Musculoskeletal (arthritis, fractures, sprains)			
Genito-urinary (kidney stones, bladder or kidney infections, prostate problems)			
Skin (masses, blisters, dermatitis, eczema)			
Neurologic (problems with swallowing, seizures, tingling, numbness, severe headaches)			
Psychiatric (anxiety, depression, other)			
Endocrine (increased thirst, diabetes,)			
Hematological (bleeding or clotting problems, anemia, swollen or enlarged lymph nodes)			
Immunological (hay fever, lupus, HIV/AIDS)			

Please list any **other medical problems** for which you are being treated: _____

Please circle if any of your **immediate family members (Parents, Children, Siblings)** have had the following:

Diabetes	Hypertension	Stroke	Gout
Heart attack	Cancer	Depression	Arthritis
Rheumatoid	Kidney Disorder	Other _____	

Are you married? Yes No Other Relationship: _____ Children? No Yes #____
 Do you smoke or use tobacco? Yes No How many packs per week? _____
 Do you consume alcohol? Yes No How many glasses-bottles/week? _____
 Do you currently or have you ever had a problem with drug or alcohol abuse? Yes No

Patient's signature _____ Date _____

Physician's signature _____ Date _____