The
Anderson
Orthopaedic
Clinic
A Center of Excellence
for Orthopaedics

SAMEER H. NAGDA, M.D.
NEW PATIENT FORM

NAME____ **TODAY'S DATE**__________

AGE___________ **DATE OF BIRTH** _________ **OCCUPATION**_______________________

PRIMARY CARE PHYSICIAN____________________

ARE YOU RIGHT OR LEFT HANDED? ________

CHIEF COMPLAINT: Shoulder Elbow Knee Ankle OTHER:______________________
(please circle)
SIDE: Right Left Both

REASON FOR VISIT:____

____

WHEN DID YOUR SYMPTOMS START? ____

DID YOU HAVE A SPECIFIC INJURY? (please circle) YES NO

If yes please describe :____

WAS THE INJURY WORK RELATED? (please circle) YES NO

ARE YOUR INJURIES RELATED TO A MOTOR VEHICLE ACCIDENT? (please circle) YES NO

HOW SEVERE IS YOUR PAIN (On a scale of 0-10 with 10 being the worst pain ever felt)? __________

TYPE OF PAIN: Dull Sharp Throbbing Achy Stabbing Shooting Other_____________
(circle all that apply)

DOES YOUR PAIN AWAKEN YOU FROM SLEEP? (please circle) YES NO

DO YOU GET PAIN WITH (please circle):

Overhead Activities Throwing Lifting Carrying Reaching

Squatting Weight Bearing Activities At Rest Climbing Stairs None of the above

WHICH OF THE FOLLOWING SYMPTOMS IS THE MOST BOTHERSOME (please circle one):

Pain Weakness Stiffness Instability

Reviewed:______________

DO YOU GET ANY OF THE FOLLOWING: (circle all that apply)

Weakness Instability Swelling Clicking Numbness Night Pain

Stiffness Loss of Range of Motion Catching Tingling Neck Pain

NONE OTHER SYMPTOMS:____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM (circle all that apply):

X-rays MRI EMG Physical Therapy Ice Heat Medications Injections

Surgery None Other__________________________________

PAST MEDICAL HISTORY: (Please circle Yes or No for the following medical conditions)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Issues	Yes	No	Stroke	Yes	No	Cancer	Yes	No
HIV/AIDS	Yes	No	Stomach Issues	Yes	No	Latex Allergy	Yes	No
Thyroid Issues	Yes	No	Hepatitis	Yes	No			
Blood Clots	Yes	No	Other______________________					

PAST SURGERIES AND APPROXIMATE DATES:

____

____

DRUG ALLERGIES: ____ None ___________

CURRENT MEDICATIONS: None_________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

FAMILY HISTORY: (any medical problems in your blood relatives)

Mother:_________________________ Father:______________________ Siblings:__________________________

None: __________________________ Unknown: ___________________

Reviewed: _________________

SOCIAL HISTORY: Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Currently Smoke, How may per day?__________ ☐ Quit/When:__________

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily (how much):_______________

Drug Use: ☐ Never ☐ Type and Frequency ____

REVIEW OF SYSTEMS: Do you have trouble with any of the following? (Please circle Yes or No)

Headache	Yes	No	Eyesight	Yes	No
Chest Pain	Yes	No	Shortness of Breath	Yes	No
Swallowing	Yes	No	Hearing	Yes	No
Blood in Stool	Yes	No	Diarrhea	Yes	No
Painful urination	Yes	No	Night Sweats	Yes	No
Constipation	Yes	No	Leg swelling	Yes	No
Weight loss	Yes	No	Blood Clots	Yes	No
Easy Bleeding	Yes	No	Tired/fatigue	Yes	No
Balance	Yes	No	Rashes	Yes	No
Depression/anxiety	Yes	No	Joint pains (multiple)	Yes	No
Joint swelling (local)	Yes	No	Soft tissue swelling	Yes	No
Muscle aches	Yes	No			

Patient Signature:____Date:___________________________
(Or the person who is filling out this form)

Reviewed: ________________

For office use only:

Height: __________

Weight: __________

BP: __________

Pulse: __________

Sameer Nagda, MD
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Anderson Orthopaedic Clinic
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How did you hear about us?

We are always interested in knowing how our new patients heard about our practice. If you could please take a moment to let us know, we would greatly appreciate it! Thank you!!

I was referred by: (check all that apply)

☐ A primary care physician/ internal medicine or family practice physician
Name:____

☐ An Orthopaedic Surgeon
Name:____

☐ A Chiropractic physician
Name:____

☐ A Physical Therapist
Name:____

☐ A current or past patient of ours
Name:____

☐ A Professional, Collegiate, or High School coach or trainer
Name:____

☐ An Internet Website
Name:____

☐ A newspaper advertisement or article

☐ An advertisement at a professional sporting event

☐ A Yellow pages ad/ Phonebook

☐ A worker’s compensation referral

☐ Other:____