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New Patient Medical Profile for Dr. Sean Baran

Patient Name:______________________________________

Date of Birth: ____/____/____ Age: _________

Visit Information

Reason for visit: ______________________________ Primary Care Physician: ____________________

How did you hear about us? ____

Type of pain: ◻ Ache ◻ Sharp ◻ Throb ◻ Shooting ◻ Dull ◻ Click/Pop Date of Injury: ___/___/___

Severity: None 0 1 2 3 4 5 6 7 8 9 10 Intolerable Duration of pain: __________ Location: ____________

__________ ____________

Pain Aggravated By:

☐ Standing ☐Walking ☐Lying
☐Sitting ☐Working ☐Stairs
☐Sleeping ☐Driving

Treatments Attempted:

☐Pain Medication ☐NSAID ☐ Rest
☐ Cane/Walker ☐Wheelchair ☐Ice
☐Physical Therapy ☐Surgery ☐ NONE

Medical History

Please list any heath problems that you are currently diagnosed with:

☐Diabetes ☐High Blood Pressure ☐ Heart Disease ☐DVT (blood clots)
☐Liver Disease ☐ Kidney Disease ☐Cancer ☐ Pulmonary Embolism
☐Lung Disease ☐Asthma ☐ Stomach Ulcers ☐ Rheumatoid Arthritis
☐Thyroid Problems ☐ Depression ☐Chronic Headache ☐ Osteoarthritis/Gout

☐Infections: Please explain: ______________________________ Height ____________

☐Other Illnesses: ______________________________________ Weight ____________

Surgical History

Please list any previous surgeries and approximate date.

Surgery:	Date:	Surgery:	Date:
______________________________	___/___/___	______________________________	___/___/___
______________________________	___/___/___	______________________________	___/___/___
______________________________	___/___/___	______________________________	___/___/___
______________________________	___/___/___	______________________________	___/___/___

◻ NONE Known Allergies to Anesthesia: ◻ Y ◻ N Describe: ____________________

Medications

Please list any medication you currently use, including prescription, over the counter, vitamins, herbs.

Medication:	Dose:	Medication	Dose:
________________________	______	________________________	______
________________________	______	________________________	______
________________________	______	________________________	______
________________________	______	________________________	______
________________________	______	________________________	______
________________________	______	________________________	______

Allergies

Known Drug Allergies:

☐ **None Known** ☐Penicillin ☐ Sulfa ☐ Iodine
☐ Latex ☐ Aspirin ☐Codeine ☐ Ibuprofen
☐Other:

Please Turn Over →

Family History

Please indicate if your have family members with these problems (father, mother, sibling, child):

Diabetes ☐ Yes ☐ No ____________________ Blood Clots ☐ Yes ☐ No ____________________

Heart Disease ☐ Yes ☐ No ____________________ Sleep Apnea ☐ Yes ☐ No ____________________-

Hip Problems ☐ Yes ☐ No ____________________ Arthritis ☐ Yes ☐ No ____________________

Cancer ☐ Yes ☐ No ____________________

Social History

Occupation: ______________________________ ☐ Disabled Reason for disability:____________________

☐ Retired ____________________

Do you live alone: ☐ Yes ☐ No With whom: ______________________________

Do you smoke? ☐ Yes ☐ No ______ packs/day Quit: _______ Months Ago _______ Years Ago

Do you drink Alcohol? ☐ Yes ☐ No Number of drinks__________ ☐ Daily ☐ Monthly ☐ Infrequently

Do you use recreational drugs? ☐ Yes ☐ No Please List: ______________________________

Review of Systems

General	Fever Chills	Weight Loss Weight Gain	Fatigue Night Sweats	Decreased appetite
Eyes	Blurred Vision Glaucoma	Pain Glasses	Sore Contacts	Vision Loss
Ear, Nose, Throat	Hearing Loss	Sore	Inflammation	Dentures
Cardiovascular	High Cholesterol Palpitations	Heart Attack/Stents Heart Murmur	Chest Pain Shortness of Breath	Leg Swelling Aortic Aneurysm
Respiratory	Sleep Apnea COPD	Emphysema Wheezing	Tuberculosis Coughing	Sputum
Gastrointestinal/ Urinary	Bladder Infections Incontinence	Kidney Stones Burning	Hemorrhoids	
Musculoskeletal	Injury	Joint Pain	Muscle Pain	Swelling
Skin	Rash	Cellulitis	Color change	Bruising
Neurologic	Dizziness Fainting	Numbness Tingling	Headaches Balance Trouble	Stroke Memory Trouble
Hematologic/Lymph	Edema	Anemia	Bleeding Disorder	Leukemia
Immunologic	HIV	AIDS	Hepatitis	Sexually Transmitted Disease
Psychological	Depression Anxiety	Sleep Trouble	Personality Disorder	Mania
Other:				

Miscellaneous

Is there any other information relevant to your visit today?

Signatures

Patient Signature: ____ ___/___/___

Physician Signature: ____ ___/___/___