NEW PATIENT EXAM FORM

Patient's Name:_____**MR#**_____

Age:_____ DOB:_____ Referring Physician:_____

Chief Complaint: RT / LT _____

History:_____

_____

_____

_____

Past Medical History:

Medications:_____

_____

_____

Allergies:_____

Previous Operations:_____

_____

_____

Previous Hospitalizations:_____

Review of Systems:

Cardiovascular: [ ] Chest pain [ ] MI [ ] CVA [ ] TIA [ ] PVD [ ] HTN _____

Respiratory: [ ] Asthma [ ] Pneumonia [ ] TB [ ] COPD_____ Renal_____

Gastrointestinal:_____ Diabetes:_____

Hepatic:_____ Thyroid:_____

Social History:

Occupation:_____ [ ] RT Handed [ ] LT Handed

Habits: [ ] Alcohol_____ [ ] Tobacco_____ [ ] Drugs _____

Coagulation: Personal history of easy brusing/bleeding:_____

Physical Examination:

Height:_____ Weight:_____ BP:_____ Pulse:_____ Respirations:_____ Temp:_____

	Right	Left		Right	Left		Grip Strengths				
Thigh Circumferences:	_____	_____	Pedal Pulses:	_____	_____	Rt.	_____	_____	_____	_____	_____
Calf Circumferences:	_____	_____	Posterior:	_____	_____	Lt.	_____	_____	_____	_____	_____

X-Ray:_____