UT PHYSICIANS **NEW PATIENT HISTORY** **DR. JAFARNIA**

Last Name:	First name:	Age and date of birth:
Email Address:	Pharmacy Phone & Address:	
Occupation/Company or Grade/School:		
Work status: □ Full Time □ Part Time □ Retired □ Disabled □ Volunteer □ Not Currently Employed		
Who is your Primary Care Physician?_____ Last visit to him/her? ___/___/_____		
Current Height: ____Weight:_____ Marital Status: □ Single □ Married □ Divorced □ Partnered □ Separated □ Widowed		

DESCRIPTION OF INJURY/SYMPTOMS: (please circle or print)

Location of the injury/problem: right/left/bilateral (arm, shoulder, elbow, forearm, wrist, hand, thumb, index finger, middle finger, ring finger, small finger)

Date of 1st symptoms/injury (if any):_____

How the injury/symptoms began:_____

Where the injury occurred: home/auto/work/other:_____

Rate your pain/symptoms: none/mild/moderate/severe

Describe the symptoms: sharp, dull, aching, throbbing, burning, constant, intermittent, worsening, improving, unchanged, other:_____

Do you have any: swelling, bruising, numbness, tingling, snapping, stiffness, deformity, open wounds, weakness, other:_____

When to the symptoms occur: activity/sleeping/work/cold/driving/other:_____

What improves symptoms: rest, ice, heat, brace, medication (list type), brace, injection, other:_____

Previous tests: x-rays, nerve tests, MRI, CT scan, other:

MEDICAL HISTORY: Have you ever had any of the following medical conditions? (please circle)

	Anemia		Diabetes		High Blood Pressure		Neurological		Bladder infection
	Angina		DVT		Hypothyroidism		Pregnant? Yes/No		Ulcers
	Anxiety		Diverticulitis		HIV		PE		NONE
	Asthma		Emphysema		Irregular Heart beat		Reflux		
	Bleeding Disorder		GI bleed		Kidney failure		Rheumatoid Arthritis		
	Blood clot		Heart Attack		Liver problems		Seizures		
	Cancer - type:		Heart Failure		Lupus		Sleep Apnea		
	Depression		Hepatitis A, B, C		Migraines		Stroke		

Please list your current medical conditions:_____

_____

_____

_____

SURGICAL HISTORY: (please list below) **None:_____**

Surgeries or Hospitalizations	Year	Complications (if any)

PLEASE TURN OVER AND COMPLETE BACK SIDE OF PAGE →→→→→→→→→→→→→

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CURRENT MEDICATIONS: (please list below) **None:_____**

Medication name	Dose	How often

ALLERGIES: Do you have an allergy to (please circle): latex, adhesive tape, anesthetics, iodine, IV contrast, none
Do you have any other ALLERGIES? □ NO □ YES (please list below):

Allergies:	Type of reaction:

REVIEW OF SYSTEMS:

Have you had any of the following recently? (please circle): fevers, chills, fatigue, exercise intolerance, sleep problems, blurry vision, decreased hearing, sore throat, ears ringing, chest pain, fainting, shortness of breath, cough, heartburn/reflux, nausea, vomiting, constipation, diarrhea, pain on urination, abdominal pain, rash, itching, loss of balance, history of seizures, anxiety, depression, weight change, continuous thirst, hives, hay fever, easy bruising, easy bleeding, enlarged lymph nodes
None of the above:_____

IMMUNIZATIONS: Are your immunizations up to date? □ NO □ YES

Tetanus (Year)?		Flu Shot (Year)?		Pneumonia Vaccine (Year)?	

FAMILY HISTORY: Do any of the following diseases run in your family?: **None:_____**

Disease	Mother	Father	Siblings	Children
Heart disease / heart attack				
High blood pressure				
Cancer (type)				
Stroke				
Bleeding disorders				
Seizures				
Mental illness				
Diabetes				

SOCIAL HISTORY/HABITS PLEASE CIRCLE

Do you smoke cigarettes?	Yes	No	How many packs per day?		How many years?		Year quit?	
Other tobacco/nicotine?	Yes	No	Type and amount		How many years?		Year quit?	
Do you drink alcohol?	Yes	No	How many drinks per week?					
Do you use illegal drugs?	Yes	No	Type					

How would you describe your health?	**Excellent**	**Good**	**Fair**	**Poor**

What is your hand dominance (please circle): RIGHT / LEFT / Ambidextrous

What type of exercise or sport do you participate in?

Sport	Daily	Weekly	Monthly	Rarely

PLEASE SIGN:_____ **Date:_____** Physician/PA signature:_____