Dr. Frankenhoff
Orthopedic Surgery New Patient History Form

Date: _____
Patient Name:_____ Age: _____ Birthdate: _____
Referred by: _____ Primary Care Doctor: _____
Sports/Hobbies: _____
Please Circle: Right Handed Left Handed

CURRENT PROBLEM (Please Circle)
Wrist: Right Left
Finger: Right Left Which finger: _____
Is this due to a specific injury? Y N Injury date: _____
Injury at work? Y N Injury date: _____
Briefly describe the injury/problem: _____
_____

SOCIAL HISTORY (Please Circle)
Marital Status: M S W D O
Are you currently disabled Y N If yes, date disability began: _____
Occupation: Current employment status: Retired Unemployed Employed Homemaker Disabled
Current Occupation: _____ Prior Occupation: _____
Habits: (Indicate if you have ever used any of the following substances)

Substance	Currently Use	Previously Used	Type/Amount/Frequency
Tobacco	Y N	Y N	_____
Alcohol	Y N	Y N	_____
Drugs	Y N	Y N	_____

MEDICAL HISTORY
Medications including topical and over counter: _____
_____
Do you take Aspirin? Y N If so, dosage and how often? _____
Medical Illnesses: _____
_____
Surgical History: _____
_____
Drug Allergies and Reaction: _____
Latex sensitvity? Y/N

REVIEW OF SYSTEMS
Are you currently having or had problems with: (please describe all that apply)
Thyroid/Diabetes_____ Seasonal allergies/autoimmune_____
Lungs/Breathing_____ Skin Rashes/Lesions_____
Bleeding_____ Numbness/Tingling_____
SwellingLegs/Feet_____ Joint Pain/Swelling_____
Fever/Sweats/Weight Loss_____ Psychological (anxiety,depression)_____

FAMILY HISTORY
Do you have Parents, Siblings or children with:
_____ Heart Disease
_____ Cancer
_____ Auto-Immune Diseases (Rheumatoid Arthritis/Lupus)

Patient Signature:_____ Date: _____
Physician Signature:_____ Date: _____