Anderson Orthopaedic Clinic SINCE 1941
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

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:____

Reviewed:_______________

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: __________________

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 ____

Reviewed: ________________

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)

PREFERRED EMAIL: ____

PREFERRED PHARMACY (Name and #): ____

Reviewed: _________________

For office use only:

Height: __________

Weight: __________

BP: __________

Pulse: __________

- ☐ Smoking Education
- ☐ Weight Management
- ☐ Diabetes Education

Sameer Nagda, MD
Sports Medicine and Shoulder Surgery
Anderson Orthopaedic Clinic
www.AndersonClinic.com

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:____