Emkey
Arthritis & Osteoporosis Clinic
Comprehensive & Compassionate Care

NEW PATIENT HISTORY FORM

Name: _____ Date of first appointment: ___/___/____

Birthplace: _____ Birthdate: ___/___/____ Age: _____ Gender (circle one): Male Female

Marital Status (circle one): Single Married Divorced Separated Widowed

Spouse/Significant Other: Alive/Age: _____ Deceased/Age: _____

Education (Circle highest level attended): Grade school High School College Graduate School

Occupation: _____ # of hours worked per week (average): _____

Referred by (circle one): Self Family Friend Doctor Web Other: _____

Name of person making referral: _____ Primary Care Physician: _____

Do you have an orthopedic surgeon? (circle one) Yes No If yes, name:_____

Briefly describe your present symptoms: _____

_____

Date symptoms began (approximate): ___/___/____ Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery, medications and injections):

_____

Please list the name(s) of other practitioner(s) you have seen for this problem: _____

_____

Medical History (please list all medical problems for which you have been diagnosed and treated):

_____; _____; _____; _____;

_____; _____; _____; _____;

Surgical History (please list all previous operations, name of hospital, reason for surgery and approximate date of surgery):

_____

_____

_____

1200 Broadcasting Road | Suite 200 | Wyomissing, PA 19610
(tel) 610.374.8133 | (fax) 610.375.1206

Medications (please list ALL medicines, including non-prescription and vitamins and supplements):

_____; _____; _____; _____;

_____; _____; _____; _____;

Allergies (please list all allergies and bad reactions to medicines and medical products):

_____

_____

_____

Preferred Pharmacy:

Pharmacy Name: _____ Pharmacy Location: _____

Pharmacy Phone# _____

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