PENINSULA
BONE AND JOINT CLINIC

NEW PATIENT INFORMATION

DR. TODD KIM
ORTHOPEDIC SURGEON

Preferred Patient Name:
Last Name:
Pronouns (e.g. , he, she, they):
Today's Date:

GENERAL INFORMATION

Who referred you to this office?
Primary Care Physician:
Currently working? ☐ YES ☐ NO Occupation:

What is your reason for visit today? **When did this start?**

☐ Right ☐ Left

Was there an accident or activity that started this? If so please state:

Is this recurrent or has this happened before? If so, please explain:

Does it cause you difficulty sleeping? ☐ YES ☐ NO What is your pain at its worse (scale 0-10)?

What symptoms are you having? (Please Select):

◯ Pain ◯ Stiffness ◯ Weakness ◯ Cracking/Popping ◯ Giving out
◯ Instability ◯ Swelling ◯ Numbness ◯ Burning/Tingling ◯ Other:

What treatments have you tried for this issue?

What is the most important thing that you want to make sure gets accomplished today?

Please select what you may be interested in today:

◯ Diagnosis ◯ Physical Therapy ◯ Surgical Options ◯ Non-surgical Options ◯ Injection
◯ X-Ray ◯ MRI ◯ Reassurance ◯ Other:

PERSONAL INFORMATION

What types of exercise or sports do you do? How often?
Who lives at home with you? Are you: ◯ Right handed ◯ Left handed ◯ Both

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MEDICAL HISTORY

Please list any past orthopedic surgeries or injuries (and approximate year) that may be related to your condition today (e.g. "right shoulder surgery 2019" if you are here for shoulder pain today):

Please answer the following questions:

Do you have diabetes? ☐ NO ☐ YES – last known HbA1c? ____

Do you smoke cigarettes or vape? ☐ NO ☐ YES – how many packs a day? ____ ☐ Former Smoker

Do you drink alcohol? ☐ NO ☐ YES – how many drinks per week? ____

Do you have allergies to lidocaine or local anesthetic? ☐ NO ☐ YES

Are you on blood thinners (Eliquis, Coumadin, Xarelto, Plavix)? ☐ NO ☐ YES : ____

Have you or immediate family ever had a blood clot in the leg or lungs (DVT, pulmonary embolism)?

☐ NO ☐ NOT SURE ☐ YES – please provide details: ____

REVIEW OF SYSTEMS:

Do you have any problems with… (please check any that apply):

General	Fever	Chills	Sweats	Unexplained weight gain/loss	Excessive thirst/urination
Cardiovascular	◯ Chest Pain	◯ Palpations			
Respiratory	Cough/Wheeze	Difficulty Breathing			
Gastrointestinal	◯ Heartburn/Reflux	◯ Stomach Ulcers	◯ Abdominal Pain		
	◯ Nausea/Vomiting	◯ Diarrhea	◯ Bloody Stools		
Genito-Urinary	Incontinence	Retention	Recurrent UTI		
Endocrin	◯ Diabetes				
Skin	Eczema	Rash	Allergic Dermatitis		
Hematologic	◯ Excessive Bleeding	◯ Easy Bruising	◯ Family History of Bleeding Disorders		
Neurologic	Headaches	Dizziness/Light Headedness	Numbness	Weakness	Foot Drop
Rheumatologic	◯ Rheumatoid Arthritis				
Mental Health	Anxiety/Stress	Trouble Sleeping	Depression	Mania	

Do you need any of the following? ☐ School/PE Note ☐ Work Note ☐ DMV Placard*

**temporary DMV placards are issued ONLY for patients undergoing surgery*

Office use only – DO NOT write below this line

Physician Signature: _____ Date: _____

I have reviewed and discussed this with the patient.