

DONALD E. BAXTER, M.D.

New Patient Questionnaire

Date of this visit _____ Referring Physician _____

Patient Name: _____ DOB: _____ Age: _____

Please describe the problem(s) for which you are here today: _____

If injury, where did it occur (circle one) Home School Auto Work Other _____

Date of Injury or date symptoms first started: _____ Which side? Right Left

Describe the type of pain you are having: (circle all that apply) Sharp Aching Stabbing Dull
Cramping Throbbing Burning Constant Pins & Needles Comes & Goes

On a scale of 1-10, how severe is the pain (1=no pain, 10=worst pain) _____

What makes the pain worse? _____

What makes the pain better? _____

REVIEW OF SYSTEMS

What medical conditions do **you** currently have? (Circle all that apply)

Childhood Disease	Peptic Ulcers	Diabetes	Bleeding Problems
Tuberculosis	High Blood Pressure	Colitis	Heart Problems
Asthma	Kidney Problems	Arthritis	
Blood Clots	Hepatitis	Other : _____	

Please list any other medical problems not listed above: _____

Females: Are you pregnant? YES NO

FAMILY MEDICAL HISTORY

Please circle any of the following medical problems anyone in **your immediate family** has had .

Childhood disease	Peptic Ulcers	Diabetes	Bleeding Problems
Tuberculosis	High Blood Pressure	Colitis	Heart Problems
Asthma	Kidney Problems	Arthritis	
Blood Clots	Hepatitis	Other: _____	

