

**Anderson Orthopaedic Clinic  
Sameer Nagda, MD  
New Patient Form**

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

ARE YOU RIGHT OR LEFT HANDED: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

CHIEF COMPLAINT: SHOULDER ELBOW KNEE ANKLE OTHER: \_\_\_\_\_  
(please circle)  
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

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 (circle all that apply):

Overhead Activities Throwing Lifting Carrying Reaching  
Squatting Weight Bearing Activities At Rest Climbing Stairs

WHICH OF THE FOLLOWING SYMPTOMS IS THE MOST BOTHERSOM (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

OTHER SYMPTOMS: \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM (circle all that apply):

X-rays MRI EMG Physical Therapy Ice Heat  
Medications Injections Surgery Other \_\_\_\_\_

Reviewed: \_\_\_\_\_

**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 Problems | Yes | No | Stroke           | Yes | No | Cancer           | Yes | No |
| Bleeding Problems    | Yes | No | HIV/AIDS         | Yes | No | Stomach Problems | Yes | No |
| Latex Allergy        | Yes | No | Thyroid Problems | Yes | No | Sleep Apnea      | Yes | No |
| Hepatitis            | Yes | No | Blood Clots      | Yes | No | Other_____       |     |    |

**PAST SURGERIES AND APPROXIMATE DATES:**

\_\_\_\_\_

\_\_\_\_\_

**DRUG ALLERGIES:** \_\_\_\_\_

**CURRENT MEDICATIONS:**

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** (any medical problems in your blood relatives)

Mother:\_\_\_\_\_ Father:\_\_\_\_\_ Siblings:\_\_\_\_\_

**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\_\_\_\_\_

**REVIEW OF SYSTEMS:** Do you have trouble with any of the following? (mark all that apply)

|                  |                     |             |                   |
|------------------|---------------------|-------------|-------------------|
| Headache         | Eyesight            | Hearing     | Swallowing        |
| Chest Pain       | Shortness of Breath | Diarrhea    | Constipation      |
| Poor Circulation | Blood in Stool      | Ulcers      | Painful Urination |
| Leg Swelling     | Night Sweats        | Weight loss | Balance Rashes    |

Patient Signature:\_\_\_\_\_

(Or the person who is filling out this form)

Date:\_\_\_\_\_

Reviewed:\_\_\_\_\_

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

## How did you hear about us?

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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: \_\_\_\_\_

2445 Army Navy Drive  
 Arlington, VA 22206

2501 Parkers Lane  
 Alexandria, VA 22306

Reviewed: \_\_\_\_\_