New Patient Questionnaire

Orthopedic Sports Medicine and Shoulder

HOSPITAL FOR SPECIAL SURGERY

Name:	DOB:	Date:
Height:	Weight:	Age:

What is your dominant hand? Right Left Ambidextrous

Chief Complaint

What is the reason for your visit? _____

_____

_____

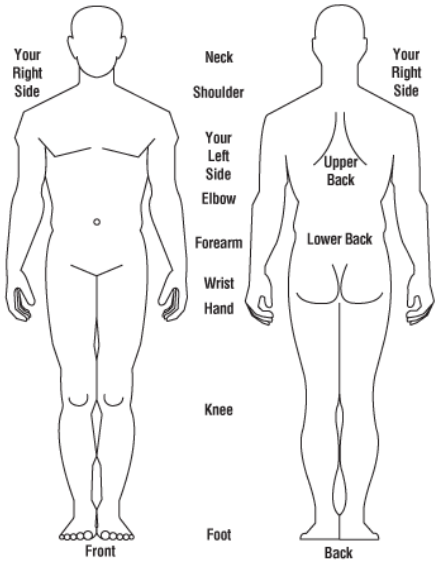
Please describe your symptoms:

Swelling	Stiffness	Locking	Instability
Giving Away	Numbness	Weakness	Tingling
Catching	Clicking	Other:	

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Please mark on the body diagram where you are experiencing pain:



When did this condition start? _____

Onset:	Gradual	Sudden	
Pain Frequency:	Constant	Intermittent	Rarely
Quality:	Sharp	Dull	Burning
	Tingling	Throbbing	Other
Night Pain:	Yes	No	
Swelling:	Yes	No	
Feels unstable/gives way:	Yes	No	
Range of Motion:	Normal	Decreased	

Everyday Activities:	No Restrictions	Limited	Unable
Recreational Activities:	No Restrictions	Limited	Unable

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you participate in any sports? _____

Level of play:	Professional	College	High School	Recreational

Have you had or tried any of the following (please select and describe)?

Type	Date Range	Location/Results	Effective?
Acupuncture Treatment			Yes No
Anti-Inflammatory Medications			Yes No
Chiropractic Treatment			Yes No
Injections			Yes No
Physical Therapy			Yes No
Massage Therapy/Deep Tissue			Yes No
MRI			
CT			
X-Ray			

Referring Physician: _____ Phone Number: _____

Screening Questions (Coordination of Care)

Are you currently on any blood thinners? Yes No

Have you ever had a MRSA Infection? Yes No

Have you had Deep Vein Thrombosis (DVT)? Yes No

Have you had a Pulmonary Embolism (PE)? Yes No

Have you ever had any problems with anesthesia? Yes No Problem: _____

Have you ever had complications from prior surgery? Yes No Problem: _____

Have you had surgery for this same condition before? Yes No

Do you have any of the following medical devices? (Mark all that apply)

Pain Pump	Neurostimulator	Pacemaker and/or Defibrillator	Shunt for hydrocephalus

Do you have diabetes? Yes No

If yes, do you have an insulin pump? Yes No

Have you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)? Yes No

For Females Only: Gynecological History

Do you think you may be pregnant at this time?	Yes No	Date:
Do you use birth control?	Yes No	Type:
Have you experienced menopause?	Yes No	When:
Have you had a hysterectomy?	Yes No	When:
Last pap smear:	Date:	
Last mammogram:	Date:	
Age you began your first period:		
When was your most recent menstrual period?	Date:	
How many periods have you had during the last 12 months?		
Number of pregnancies:		

Please list any allergies below (including medications, foods, and environment):

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	Yourself?	Family Member?	Condition	Yourself?	Family Member?
Anxiety	Yes	Yes	Open Wounds/Ulcers	Yes	Yes
Arrhythmia (Irregular heartbeat)	Yes	Yes	Osteoarthritis	Yes	Yes
Asthma	Yes	Yes	Osteoporosis	Yes	Yes
Bleeding Problems	Yes	Yes	Peripheral Vascular Disease	Yes	Yes
Blood Clots (DVT)	Yes	Yes	Pneumonia	Yes	Yes
Cancer	Yes	Yes	Psychiatric Illness (Depression)	Yes	Yes
Diabetes	Yes	Yes	Pulmonary Embolus	Yes	Yes
Heart Attack	Yes	Yes	Reflex Sympathetic Dystrophy	Yes	Yes
Heart Disease	Yes	Yes	Reflux	Yes	Yes
High Blood Pressure	Yes	Yes	Rheumatoid Arthritis	Yes	Yes
High Cholesterol	Yes	Yes	Seizures	Yes	Yes
Infection	Yes	Yes	Stroke	Yes	Yes
Kidney Disorders	Yes	Yes	Ulcers	Yes	Yes
Lung Disease	Yes	Yes	Other:	Yes	Yes

Please list the family member (father, mother, etc.) to any of the positive responses you listed above:

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Social History

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

If yes, how many drinks per week? _____

Occupation: _____ Employer: _____

Immunizations and Falls Screening:

Have you received the pneumonia vaccine? Yes No

If yes, date? _____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No

If yes, date? _____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
Activity Change	Congestion	Dryness	Chest tightness
Appetite Change	Ear pain	Discharge	Choking
Chills	Nosebleeds	Itching	Cough
Fatigue	Sinus pressure	Pain	Shortness of breath
Fever	Sore throat	Redness	Wheezing
Weight Change			
None	None	None	None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
Chest pain	Abdominal pain	Cold intolerance	Difficult urination
Leg swelling	Blood in stool	Heat intolerance	Flank pain
Palpitations	Constipation	Excessive thirst	Frequent urination
Poor circulation	Heartburn	Excessive hunger	Painful urination
	Nausea		
None	None	None	None

Musculoskeletal	Skin	Environmental Allergies	Neurological
Joint pain	Color change	Pollen	Dizziness
Joint stiffness	Hair loss	Dust Mites	Headaches
Joint swelling	Rash	Pets/Animals	Light-headedness
Joint warmth/heat	Skin tightening	Mold/Mildew	Memory loss
Muscle pain	Wound		Numbness
			Weakness
None	None	None	None

Hematologic	Psychiatric	Other
Enlarged lymph nodes	Agitation	
Bruises	Hyperactive	
Clotting problem	Nervous/anxious	
Excessive bleeding	Depression	
None	None	