New Patient Questionnaire



Orthopedic Sports Medicine and Shoulder

Name:				1	DOB: Date:							
Height:				Weight:			Ag	e:				
What is	your dom	ninant han	ıd?			Right		Left		Am	bide	xtrous
Chief Co	mplaint											
What is	the reaso	n for you	r visit? _									
Please d	escribe y	our sympt	coms:									
Swellir			Stiffn			Locking				nstability	/	_
Giving			Numb			Weaknes Other:	S		Т	ingling		
Current		.l /no :==!:=	Clickin			other:						
O	Pain Leve	el (no pain 2	3 - 10 ni	ignest):	5	6	7		8	9		10
l I		I		I		l	l.		<u> </u>			10
riedse II	Please mark on the body diagram where you are experiencing pain: When did this condition start?											
Your ()	Neck	(Your	When did	this cond	dition start	·					
Right Side	Should	er	Right Side	Onset:			Γ	Gra	dual	S	udd	en
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Your Left	\ \June	ar I	Dain Fra		C = = 1 =		- خدرا	una !±1		I	
/	Side) Bac		Pain Freq	uency:	Consta	IIIL	inte	rmitte	ent F	arel	у
// °	Foream	m / Lower E	Back \	Quality:		Sharp		Dull			urni	
	Wrist Hand	/ 4 1 \ /\		Quanty.		Tinglin	g	Thro	obbin	g (the	r
(2)) W Hall	8		Night Pair	n:			Yes		١	lo	
	Knee) \		Swelling:				Yes		N	lo	
\		())	Feels uns	table/give	es way:		Yes		ı	lo	
	è Foot			Range of	Motion:			Nor	mal		ecre	eased
Front		Baci						-				
Everyday	y Activitie	es:	No Res	strictions	Limite	d Ur	nable					
Recreati	Recreational Activities: No Restrictions Limited Unable											
Does any	ything ma	ake the pa	in better	?								
Does any	ything ma	ake the pa	in worse	?								
Do you p	articipat	e in any s _l	oorts?									
Level of	plav:	Professio	nal	College	Hig	h School	Recr	eation	nal			

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

Туре	Date Range	Location/Results	Effec	tive?
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				
СТ				
X-Ray				

Are you currently on any blood thinners? Are you ever had a MRSA Infection? Have you had a Pulmonary Embolism (PE)? Have you ever had any problems with anesthesia? Are you ever had any problems with anesthesia? Busy ou have any or this same condition before? Are you have any of the following medical devices? (Mark all that apply) Pain Pump Are you have an insulin pump? Are you have an insulin pump? Are you have an insulin pump? Are you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)? For Females Only: Gynecological History Do you think you may be pregnant at this time? Are you bed and a hysterectomy? Are you had a hysterectomy? Are you had a hysterectomy? Are you began your first period: When was your most recent menstrual period? Date: How many periods have you had during the last 12 months?	Referring Physician:	Phone Nur	nber:		
Are you currently on any blood thinners?	Screening Questions (Coordination of Care)				
Have you had Deep Vein Thrombosis (DVT)? Have you had a Pulmonary Embolism (PE)? Have you ever had any problems with anesthesia? Have you ever had complications from prior surgery? Have you had surgery for this same condition before? Have you had any or the following medications before? Pain Pump Neurostimulator Pain Pump Neurostimulator Pacemaker and/or Defibillator Yes No If yes, do you have an insulin pump? Yes No Have you been taking opioids for 6 months or more (e.g. coderne, percocet, morphine, Vicodin, etc.)? For Females Only: Gynecological History Do you think you may be pregnant at this time? Yes No Date: Have you bad a hysterectomy? Have you had a hysterectomy? Have you had a hysterectomy? When was your first period: When was your most recent menstrual period? How many periods have you had during the last 12 months?				Yes	No
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When was your most recent menstrual period? Date: How many periods have you had during the last 12 months?	Last mammogram:	Date:			
How many periods have you had during the last 12 months?	Age you began your first period:				
	When was your most recent menstrual period?	Date:			
Number of pregnancies:	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

Juigicul una mospitulization mistory			
Previous Operation/Hospitalization	Occurrence Date (appro	ox.)	
1.			
2.			
3			
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?	f not, why?		
In the past year, did you received the Influenza (f	lu) vaccine between October 1st and	Yes	No
March 31st?	f yes, date?		
Have you fallen 2 or more times within the past y	ear, 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		