Name: _____ Date of Birth: _____ ☐ M ☐ F

Chief Complaint: ☐ Right ☐ Left ☐ Both ☐ Knee ☐ Hip ☐ Shoulder ☐ Elbow

History of Problem: _____

Duration (Length of Time): _____

Intensity of Pain (Scale 0-10; 0=No Pain, 10=Worst Pain Imaginable): _____

Past treatment for this problem: _____

Previous Surgeries on this area: ☐ No ☐ Yes

Type: _____ Date: _____

Type: _____ Date: _____

Medical History (Check all medical problems you have been or currently are being treated for):

N	Y		N	Y		N	Y	
		High Blood Pressure			Stroke			Parkinson's Disease
		Heart Disease/Heart Attack			Blood Clots			Multiple Sclerosis
		Irregular Heart Rhythm			Diabetes			Seizure/Epilepsy
		Peripheral Vascular Disease			Cancer			Nerve Injury
		Emphysema/COPD/Asthma			Ulcer			Hepatitis ☐ A ☐ B ☐ C
		Sleep Apnea			Kidney Disease			Immunodeficiency Disease (HIV)
		Tuberculosis (TB)			Thyroid Disease			Degenerative Spine Disease Sciatica
		GERD Heartburn			Brain Injury			Arthritis/Osteoporosis

Surgical History (List all other surgeries you have had):

Year	Type of Surgery	Year	Type of Surgery

List all Medications you take regularly (include non-prescription meds): ☐ See Attached List

Name & Dose	How Often	Name & Dose	How Often

ORTHOPAEDIC SURGERY
SPORTS MEDICINE
NEW PATIENT QUESTIONNAIRE

PATIENT ID

Allergies: ☐ No ☐ Yes If yes, please list medication and reaction to it below:

Medication	Reaction	Medication	Reaction

Complications (Check and explain any complications you have had after any of your surgeries):

	Infection:		Pneumonia:
	Bleeding:		Lung Problems:
	Blood Clot:		Severe Nausea/Vomiting:
	Anesthesia Reaction:		Other:

Social History:

Occupation: _____ ☐ Full Time ☐ Part ☐ Retired

Do you drink alcohol? ☐ No ☐ Yes If yes, how much? ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 20 or more drinks/week

Do you currently smoke? ☐ No ☐ Yes If yes, number of packs per day: _____ For _____ years

Did you ever smoke? ☐ No ☐ Yes If yes, number of packs per day: _____ For _____ years Year quit: _____

History of Substance Abuse? ☐ No ☐ Yes If yes, what substance: _____

Review of Symptoms (Check any recent/current problems, check symptoms or write in other):

N	Y	System	Symptoms/Problems	Other
		General	☐ Fever, ☐ Unexplained Weight Loss/Gain, ☐ Weakness	
		Eyes/Vision	☐ Glasses, ☐ Blurred, ☐ Double, ☐ Dry Eyes	
		Ears, Nose, Throat, Mouth	☐ Vertigo, ☐ Sinusitis, ☐ Hoarseness, ☐ Loss of Hearing	
		Heart	☐ Chest Pain, ☐ Murmurs, ☐ Palpitations, ☐ Irregular Rhythm	
		Lung	☐ Short of Breath, ☐ Asthma, ☐ Cough, ☐ Wheezing	
		Circulation	☐ Blood Clots, ☐ Swelling, ☐ Claudication, ☐ Varicosities	
		Digestive Tract	☐ Diarrhea, ☐ Constipation, ☐ Ulcers, ☐ GERD, ☐ Pain	
		Kidney/Urinary	☐ Stones, ☐ Burning, ☐ Itching, ☐ Bleeding	
		Skin/Breast	☐ Rash, Lump, ☐ Itching, ☐ Hair or Nails Change	
		Endocrine	☐ Excess Thirst, ☐ Decreased Energy, ☐ Diabetes	
		Neurologic	☐ Balance, ☐ Numbness/Tingling, ☐ Seizure, ☐ Tremor	
		Psychiatric	☐ Depressions, ☐ Anxiety, ☐ Sleep Disorder	
		Blood/Lymph	☐ Bleeding Problems, ☐ Easy Bruising, ☐ Transfusion	
		Musculoskeletal	☐ Fracture, ☐ Arthritis, ☐ Motion Loss, ☐ Cramps/Spasms	

Family History (Mark any conditions that your parents or siblings have or have had by indicating the family member [M = mother, F = Father, B = Brother, S = Sister] after the conditions):

High Blood Pressure:	Asthma:	Cancer:
Heart Attack:	Lung Disease:	Stroke:
Coronary Artery Disease:	Tuberculosis:	Diabetes:
Heart Valve Disease:	Thyroid Disease:	Kidney Disease:
Irregular Heart Rhythm:	Blood Clots:	Arthritis:
Peripheral Vascular Disease:	Seizures:	Osteoporosis:
Hepatitis: ☐ A ☐ B ☐ C	Immunodeficiency:	Other:

I certify that the foregoing statements are true to the best of my knowledge.

Patient Signature: _____ Date: _____ Time: _____

Physician (Print): _____ (Signature): _____ Date: _____ Time: _____

Vital Signs:

Temp: _____ BP: _____ HR: _____ RR:_____ Pain: _____ Height: _____ Weight: _____ BMI: _____

Medical Assistant (Print): _____ (Signature): _____ Date: _____ Time: _____