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New Patient Questionnaire
Dr. Patel

Patient Name: ____________________________ Today's Date: ______________________

DOB: ______________ Ref MD: __________________________

Address: __________________________

____

____

Age: _______________

Location of your problem: Which side? ☐Right ☐Left ☐Both

____

Please describe your problem:

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____

____

NOTES FOR DR.

What time frame has it been hurting?_______________Pain has worsened in last__________(months/year)

☐Hx of Injury: ☐No ☐Yes When/How?____

____

☐Medications tried?________________________________ Benefit?_________ ☐P.T./ last?___________

☐Hx of **Oral Prednisone**? When?_______________ Dosage?__________ How Long?_________

☐Walker/Cane…..Which hand? ☐Right ☐Left

Walking distance?_______________________________ ☐Use Rail with Stairs?

Knee Symptoms:

☐Swelling ☐Redness/Erythema

☐Giving Way/Buckling ☐Catching/Popping

☐Locking ☐Pain up/down stairs?

☐Pain with sitting/standing ☐Brace?

☐**Injections**: ☐Cortisone-Last Injection:____________

☐Visco.-Last Series completed:________

(Supartz, Hyalgan, Synvisc, Eufflexa, Orthovisc)

Hip/Lumbar Symptoms:

☐Groin Pain ☐Lateral pain

☐Pain to Knee ☐Buttock Pain

☐Low Back Pain

☐Radiculopathy(Numbness/Tingling/Burning)

How far down the leg?___________________

☐**Injections**: ☐L/S last completed:________

☐Hip- ☐Intra-articular ☐Lateral

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Patient Name: ______________________________

PAST MEDICAL HISTORY

List all medical conditions:

_______________________ _______________________
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________

Do you have any of the following:

☐Diabetes ☐Heart Disease ☐Clotting disorder ☐Cancer ☐Hepatitis ☐HIV ☐History of Blood Clots (DVT/PE)

PAST SURGICAL HISTORY

List all previous surgeries:

_______________________ _______________________
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________

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MEDICATIONS

List all medications (and dosages)

_______________________ _______________________
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________

Do you take any of the following: ☐Coumadin ☐Lovenox ☐Plavix ☐Eliquis ☐Xarelto

☐NSAIDS (i.e. Advil, Motrin, Aleve) ☐Aspirin

☐Prednisone (Last time?__________How Much?________)

ALLERGIES

List all allergies to medications and reaction which occurs:

_______________________ _______________________
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________

Allergic Reaction to: ☐Tape/Bandaids ☐Iodine (Contrast/Topical) ☐Chicken/Eggs ☐Metals or sensitivity to jewelry

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Patient Name: ________________________________

FAMILY HISTORY

List all illnesses that run in your family: ____
____

Mother's Age________ Father's Age ________

☐Alive ☐Deceased ☐Alive ☐Deceased

Cause of death:____________________ Cause of death: _________________

Sibling(s) and ages ____

SOCIAL HISTORY

Do you live alone? ☐Yes ☐No Who lives with you? ___________________

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Do you have stairs at home? ☐Yes ☐No

What type of work do you do? ____

Marital status: ☐Married ☐Divorced ☐Widowed ☐Single ☐Legally Separated

☐Life Partner ☐Registered Domestic Partner ☐Significant Other ☐Unknown ☐Other

Number of children: ______

Smoke cigarettes: ☐No ☐Yes Number of packs per day: _________

Years smoking:______Used to, but quit________months/years ago

Alcohol consumption: ☐Never ☐Used to, but quit_________years ago

☐Socially ☐Daily _____Times/week Type of Alcohol:_________________

History of illicit drug use: ☐Yes ☐No If yes, what kind?______________Last used?___________

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Patient Name: ________________________________

REVIEW OF SYSTEMS

Please place a check mark next to any symptoms you have had or currently have:

Consitutional

___Fevers, chills
___Decreased appetite, weight loss
___Night pain that awakens you from deep sleep

Eyes, Ears, Nose, Throat

___Recent changes in vision
___Glaucoma
___Any metal fragments in your eyes
___Nosebleeds
___Hearing loss
___Loss of balance

Cardiovascular

___Chest pain
___Palpitations
___Irregular heartbeat
___Shortness of breath
___High blood pressure
___Elevated cholesterol

Respiratory

___Asthma/wheezing
___Chronic cough
___COPD/emphysema
___Pneumonia or bronchitis
___Tuberculosis
___Lung cancer

Gastrointestinal

___Upset stomach
___Reflux (GERD)
___Blood in stool
___Dark black, tarry stools
___Yellow jaundice
___Gallbladder problems
___Colon cancer

Genitourinary

___Burning/pain with urination
___Urinary frequency
___Blood in urine
___History of kidney stones
___Enlarged prostate
___History of prostate cancer

Musculoskeletal

___Swelling in multiple joints
___Low back pain
___Reflex sympathetic dystrophy (RSD)

Skin

___Chronic rashes
___Eczema or psoriasis
___Skin cancer or melanoma
___Unusual birthmarks

Neurological

___History of seizures
___History of Stroke/TIA
___Dizziness
___Memory loss

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Psychiatric

___Anxiety
___Depression
___Bipolar disorder
___Schizophrenia

Endocrine

___Diabetes
___Thyroid problems
___Taking hormone replacement therapy
___Taking prednisone

Hematologic

___Anemia
___Easy bruising or bleeding problems
___History of blood clots
___History of blood transfusions

I attest that the above information is correct

______________________________ ___________
Patient signature Date

I have reviewed this information with the patient

______________________________ ___________
Physician signature Date

PLEASE STOP HERE

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