LAFAYETTE
Orthopaedic Clinic
A UNITY HEALTHCARE PARTNER

Office Use	
Referral?	
H:	
Wt:	
Pulse:	
Resp:	
RHD	LHD

New Patient or New Problem Questionnaire

Date: ________________

Age: ________
Birthday: ______________

Patient Name: ____________________________________

Who referred you to Orthopaedics? _________________________ Who is your Primary Care Doctor? __________________

What hurts? ____

When did it start (or Injury Date)? ____

Was there an injury? Yes No What happened? ____
____
____

How bad does it hurt on a scale of 1 to 10: 1 2 3 4 5 6 7 8 9 10

How often is the pain present? Intermittent Frequent Continuous

How would you describe the pain? Sharp Dull Throbbing Numb Tingling Other _______________

Is it getting better or worse? Improving Worsening Staying the same

What makes it feel better? ____

What makes it feel worse? ____

Has another doctor started a work-up of this problem? Yes No
Have you had x-rays or an MRI? Where? ____

PAST MEDICAL HISTORY:
What other medical problems do you or did you have? (please check any that apply)

High Blood Pressure	Diabetes	COPD/Emphysema	Other _______________
Osteoarthritis	Gout	Asthma	
Rheumatoid Arthritis	Cancer	Heart Disease	
Stomach Ulcers	Kidney Failure	Heart Attack (when?) __________	
tooth/gum disease	HIV/AIDS	Blood Clots	
	Hepatitis	Stroke (when?) _______________	

What medications do you take?

_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

Are you allergic to any medicines or shell fish or latex? What happens?

Bad Medicine	Reaction
___________________________	___________________________________
___________________________	___________________________________
___________________________	___________________________________

What surgeries have you had (approximate dates)

___________________________ ___________________________________
___________________________ ___________________________________
___________________________ ___________________________________

Patient Name: ____ Date: ___________

FAMILY MEDICAL HISTORY:

Do any medical problems run in your family? (please check any that apply)

Rheumatoid Arthritis   Heart Disease   Cancer   Anesthetic Problems

Osteoarthritis (regular arthritis)   Diabetes   None Apply

Other ____________________________________

SOCIAL HISTORY:

Do you smoke? No Yes (Packs/day __________; how many years? ____________)

Do you drink alcohol? No Yes (drinks per week? __________________________)

Marital Status:

Married   Widowed   Divorced   Single

Who is around to help you out while you're not feeling well?

No one   Spouse/Significant Other   Family   Roommate

I am:

Employed   Employer: _______________________   Occupation _________________________

Retired

On disability   Why: ____

In School   Studying: ____

For Minors:

Where do you go to school? What grade? ____

What are you going to be when you grow up? ____

REVIEW OF SYSTEMS: Any other medical problems? (circle all that apply)

Head	***GI***	***Heme/Lymph***	***Constitutional***
Hearing loss	GI Bleeding	Swollen glands	Weight loss
Vision loss	Stomach upset with medicines	Easy bruising	Weight gain
Nose bleeds	Reflux		Fevers
Head Aches			

Heart/Lungs	***Urinary System***	***Psych***	***Skin***
Chest pain/pressure	Frequent urinary infections	Depression	Infections (where?)_________
Palpitations	Burning with urination	Anxiety	Rash
Wheezing	Blood in urine		
Shortness of breath	Frequent urination		

Patient's Signature: ____ Date: ________________

Physician's Signature: ____ Date: ________________