New Patient Questionnaire

LAFAYETTE Orthopaedic Clinic
A UNITY HEALTHCARE PARTNER

Demographics

Name:_____ Age: _____ □M □F Dominant Hand: □R □L Height: _____ Weight: _____
Who referred you (PCP, ER, date)? _____Who is your primary care doctor? _____

History of Present Illness

What are you seeing the doctor for? Please describe primary symptom including location: _____

_____

Please describe any associated symptoms: _____
Date of injury or beginning of symptoms? _____When does it hurt? □Occasionally □ Constant □ During activity
Quality of pain (check): □Sharp □Burning □Dull □Throbbing Pain at night? □YES □NO
Severity (How bad does it hurt on a scale of 1-10?): □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
What makes it worse? _____
What makes it better? _____
What treatments have you tried or had prescribed by another Doctor (PT, meds, injections, etc)? _____

_____

Is this a Worker's Comp Claim? □YES □NO Occupation: _____ Employer/School: _____
X-rays for this injury: □YES □NO Where: _____ Help at home?: □YES □NO Who: _____

Past Medical History (Please check any conditions you've been diagnosed with)					Check here if none apply □
□ Thyroid Disease	□ Kidney Failure	□ Stroke	□ Diabetes	□ Poor Dentition	List others here:
□ High Blood Pressure	□ Heart Disease	□ Asthma	□ HIV/AIDS	□ Blood Clot (DVT)	_____
□ High Cholesterol	□ Heart Attack	□ COPD	□ Hepetitis	□_____ Cancer	_____
□ Rheumatoid Arthritis	□ Lupus	□ GOUT	□ Epilepsy	□ Stomach Ulcers	_____

Previous Surgeries	Medications (with dose)	Allergies (and reaction)	Family History
_____	_____	_____	□ Heart Disease
_____	_____	_____	□ Cancer
_____	_____	_____	□ Bleeding Problem
_____	_____	_____	□ Anesthesia Problems
_____	_____	_____	_____
_____	_____	_____	_____

Social History	Alcohol Use	Tobacco Use	Recreational Drugs	Married?
	□Yes □No	□Yes □No	□Yes □No	□Yes □No
	# of drinks /day:_____	# of packs/day:_____	If yes, what and when?	Hobbies?
		How many years?_____	_____	_____

Review of Systems (Please review all symptoms and circle any that apply to you) — Check here if none apply □

CONSTITUTIONAL
Weight loss / gain
Fevers or Chills

EYES
Corrective Lenses
Double Vision

EAR/NOSE/THROAT
Headache
Nose bleeds

CARDIOVASCULAR
Chest Pain
Palpitations

RESPIRATORY
Short of Breath
Exercise Intolerance

GASTROINTESTINAL
Nausea/Vomiting
Bloody or Dark Stools

GENITOURINARY
Frequency/Urgency
Painful Urination

MUSCULOSKELETAL
Joint Pain
Swelling
Instability
Muscle pain
Stiffness
"Catching" in Joint

SKIN
Poor healing
Infections
Redness

NEUROLOGIC
Numbness/Tingling
Unsteady Gait

HEMATOLOGIC
Easy bleeding/bruising

PSYCHIATRIC
Anxiety
Depression

ENDOCRINE
Excessive thirst
Heat/cold intolerance

ALLERGIC
Seasonal Allergies
Food _____

Your signature affirms the above information is true to the best of your knowledge and it will become a permanent part of your medical record

Patient Signature: _____ **Date:** _____

Provider Signature: _____ Date: _____

Office Use:
BP_____
P_____
R_____