ORTHOPEDIC SURGERY SPECIALISTS PLLC

New Patient History Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

Who referred you? _____

Reason for Visit: _____ Date of Injury: _____

1. History of Present Illness (HPI)

Pain – Where? _____ Describe it (burn/stab/dull, etc.) _____

When does it occur? _____ How long does it last? _____

When did your symptoms begin? _____

Rate your pain from 0 (no pain) to 10 (worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

What makes it better or worse? _____

Numbness (tingling/asleep feeling) – Where? _____

When does it occur? _____ How long does it last? _____

What makes it better or worse? _____

Other Complaints: _____

2. Past Medical History

Please circle Yes or No if you have any of the following medical problems

Diabetes	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Blood Clots	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No
Breathing Problems	Yes	No	Sleep Apnea	Yes	No
Bleeding Problems	Yes	No	High Cholesterol	Yes	No
Thyroid Disease	Yes	No	HIV	Yes	No
Liver Disease	Yes	No	Hepatitis (specify type below)	Yes	No
Cancer (specify type below)	Yes	No	Mental Illness (specify below)	Yes	No

Others (please list): _____

Past Surgeries with Dates: _____

_____

_____

Medications (doses & how often you take them): _____

_____

_____

_____

Allergies: No Yes – Please list allergy & reaction: _____

_____

Continued on next page

3. Social History

Tobacco Use:No Yes – How much? _____

Alcohol Use: No Yes – How much? _____

Marijuana Use: No Yes – How much? _____

Illicit Drug Use: _____

Occupation/Hobbies: _____

Do you use Cane, Walker or Wheelchair? _____

4. **Family History** – *Please list all medical problems of below family members*

Father: _____ Mother: _____

Siblings: _____ Other: _____

5. **Review of Systems** – *Please circle Yes or No if YOU have any of the following medical problems*

Cardiovascular			**Respiratory**			**Neurologic**		
Chest pain	Yes	No	Cough	Yes	No	Convulsions or Seizures	Yes	No
Palpitation	Yes	No	Asthma	Yes	No	Frequent headaches	Yes	No
A-fib	Yes	No	Sleep Apnea	Yes	No	Balance trouble	Yes	No
Swelling hands/feet	Yes	No	**Gastrointestinal**			**Psychiatric**		
Hematologic			Ulcers	Yes	No	Confusion/Memory loss	Yes	No
Bruise easily	Yes	No	Rectal Bleeding	Yes	No	Depression	Yes	No
Bleed easily	Yes	No	Bowel problems	Yes	No	Anxiety	Yes	No
Slow to heal	Yes	No	**Allergic/Immunologic**			Schizophrenia	Yes	No
Musculoskeletal			Food allergies	Yes	No	Bipolar	Yes	No
Muscle pain/cramps	Yes	No	Aspirin Allergies	Yes	No	**Endocrine**		
Joint stiffness	Yes	No	Antibiotic allergies	Yes	No	Thyroid disease	Yes	No
Joint pain	Yes	No	**Ear/Nose/Throat/Mouth**			Hormone problem	Yes	No
Difficulty walking	Yes	No	Hearing loss/ringing	Yes	No	Excessive thirst/urination	Yes	No
			Sinus problems	Yes	No			
			Nosebleeds	Yes	No			
			Sore throats	Yes	No			

Have you had a positive COVID-19 test within the past 3 months? No Yes

If yes, approximate date of positive test _____

Please provide the date of your most recent: Colonoscopy _____ Mammogram _____

Influenza/Flu Shot _____ Pneumococcal/Pneumonia Shot _____

If necessary, can you receive blood or blood products? Yes No

Patient Statement: To the best of my knowledge, the above information is accurate and complete

Signature: _____ **Date:** _____

****For MA Use Only**

Height: _____ Weight: _____