New Patient Questionnaire
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Primary Care Sports Medicine

HOSPITAL FOR SPECIAL SURGERY

Name:	DOB: / /	Age:

Chief Complaint

What is the reason for your visit? ____

____

____

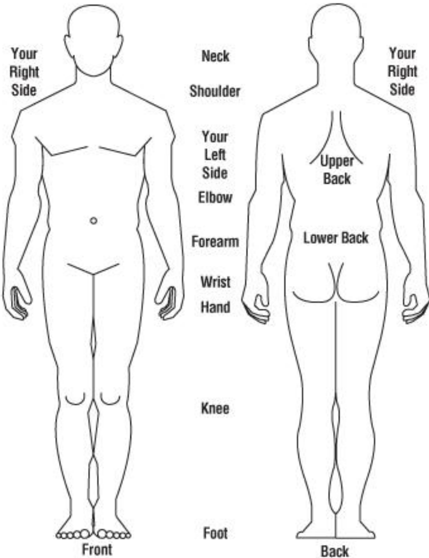
Please describe your symptoms:

Swelling	Stiffness	Locking	Instability
Giving Away	Numbness	Weakness	Tingling
Catching	Clicking	Other:	

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Please mark on the body diagram where you are experiencing pain:



When did this condition start? ____________________

Please explain how this condition started (sudden, gradual, onset):

____

Pain Frequency:	Constant	Intermittent	Rarely

Does anything make the pain better? ________________

Does anything make the pain worse? ________________

Do you participate in any sports? ________________

Level of play (please select):

Professional	College	High School	Recreational

Have you had to modify your activities? Yes No

Are you still able to play sports/exercise? Yes No

Have you had or tried any of the following (please select and describe)?

Type	Date Range	Location/Results	Effective?
Acupuncture Treatment			Yes No
Anti-Inflammatory Medications			Yes No
Chiropractic Treatment			Yes No
Injections			Yes No
Physical Therapy			Yes No
Massage Therapy/Deep Tissue			Yes No
MRI			
CT			
X-Ray			

Name: _______________________

Referring Physician: ______________________________ Phone Number: ____________________

Please list the physicians that have treated you previously for this problem:

Physician: _________________ Specialty: _____ Phone Number: ____________________

Physician: _________________ Specialty: _________________ Phone Number: ____________________

Immunizations and Falls Screening:

Have you received the pneumonia vaccine? Yes No

If yes, date? ___________________ If not, why? ___________________________

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No

If yes, date? _______________________

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

For Females Only: Gynecological History

Do you think you may be pregnant at this time?	Yes No	Date:
Do you use birth control?	Yes No	Type:
Have you experienced menopause?	Yes No	When:
Have you had a hysterectomy?	Yes No	When:
Last pap smear:	Date:	
Last mammogram:	Date:	
Age you began your first period:		
When was your most recent menstrual period?	Date:	
How many periods have you had during the last 12 months?		
Number of pregnancies:		

Name: ______________________

Please list any allergies below (including medications, foods, and environment):

	Allergy	Reaction
1.		
2.		
3.		
4.		
5.		

	Medication	Route (oral, injection, etc.)	Dose	Frequency
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety	Yes		Open Wounds/Ulcers	Yes	
Arrhythmia (Irregular heartbeat)	Yes		Osteoarthritis	Yes	
Asthma	Yes		Osteoporosis	Yes	
Bleeding Problems	Yes		Peripheral Vascular Disease	Yes	
Blood Clots (DVT)	Yes		Pneumonia	Yes	
Cancer	Yes		Psychiatric Illness (Depression)	Yes	
Diabetes	Yes		Pulmonary Embolus	Yes	
Heart Attack	Yes		Reflex Sympathetic Dystrophy	Yes	
Heart Disease	Yes		Reflux	Yes	
High Blood Pressure	Yes		Rheumatoid Arthritis	Yes	
High Cholesterol	Yes		Seizures	Yes	
Infection	Yes		Stroke	Yes	
Kidney Disorders	Yes		Ulcers	Yes	
Lung Disease	Yes		Other:	Yes	

Name: ______________________

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Social History

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

If yes, how many drinks per week? ______________________

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
Activity Change	Congestion	Dryness	Chest tightness
Appetite Change	Ear pain	Discharge	Choking
Chills	Nosebleeds	Itching	Cough
Fatigue	Sinus pressure	Pain	Shortness of breath
Fever	Sore throat	Redness	Wheezing
Weight Change			
None	None	None	None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
Chest pain	Abdominal pain	Cold intolerance	Difficult urination
Leg swelling	Blood in stool	Heat intolerance	Flank pain
Palpitations	Constipation	Excessive thirst	Frequent urination
Poor circulation	Heartburn	Excessive hunger	Painful urination
	Nausea		
None	None	None	None

Musculoskeletal	Skin	Environmental Allergies	Neurological
Joint pain	Color change	Pollen	Dizziness
Joint stiffness	Hair loss	Dust Mites	Headaches
Joint swelling	Rash	Pets/Animals	Light-headedness
Joint warmth/heat	Skin tightening	Mold/Mildew	Memory loss
Muscle pain	Wound		Numbness
			Weakness
None	None	None	None

Hematologic	Psychiatric	Other
Enlarged lymph nodes	Agitation	
Bruises	Hyperactive	
Clotting problem	Nervous/anxious	
Excessive bleeding	Depression	
None	None	