New Patient Questionnaire

Primary Care Sports Medicine

HOSPITAL FOR SPECIAL SURGERY

Name:	DOB:	Date:
Height:	Weight:	Age:

Occupation: _____

Referring Physician: _____ Phone Number: _____

What is your dominant hand? Right Left Ambidextrous

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

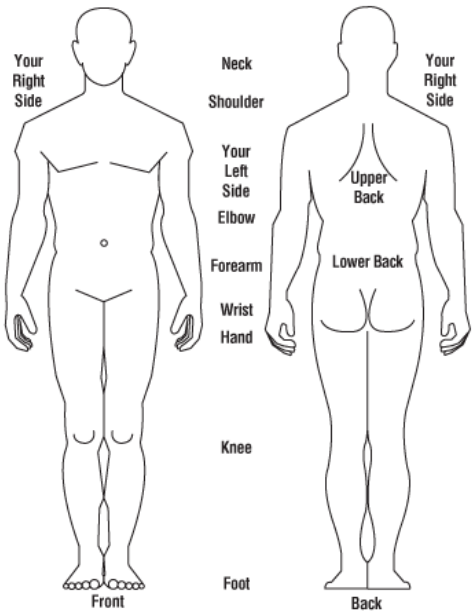
Pain Level at Best (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Pain Level at Worst (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

Describe your typical week of exercise:

_____

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			Yes No
CT			Yes No
X-Ray			Yes No
Other:			Yes No

Allergies and Medications

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 History

Please select any past medical conditions below:			
Amenorrhea (lack of periods)	Diabetes	Lyme Disease	Reflux/Heartburn
Anemia	Eating Disorder	Osteoarthritis	Rheumatoid Arthritis
Anxiety	Heart Attack	Osteoporosis	Seizures
Arrhythmia (Irregular heartbeat)	Heart Disease	Peripheral Vascular Disease	Stomach Ulcers
Asthma	High Blood Pressure	Pneumonia	Stroke
Bleeding Problems	High Cholesterol	Depression	Thyroid Disease
Blood Clots (DVT)	Kidney Disorders	Pulmonary Embolus	Other:
Cancer	Lung Disease	Reflex Sympathetic Dystrophy	

Surgical History

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

Family History

Are there any illnesses that run in the family?

Autoimmune Disease	Yes	No	Relation: _____
Arthritis	Yes	No	Relation: _____
Blood Clots	Yes	No	Relation: _____
Cancer	Yes	No	Relation: _____
Diabetes	Yes	No	Relation: _____
Heart Disease	Yes	No	Relation: _____
Hypertension	Yes	No	Relation: _____
Osteoporosis	Yes	No	Relation: _____
Other: _____			Relation: _____

Social History

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

If yes, how many drinks per week? _____

Marital Status: _____ Significant other's name: _____

Number of Children: _____

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

Review of Systems

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

Constitutional	HENT	Respiratory	Cardiovascular
Chills	Congestion	Cough	Chest pain
Fatigue	Nosebleeds	Shortness of breath	Leg swelling
Fever		Wheezing	
Unexpected Weight Change			
None	None	None	None

Gastrointestinal	Endocrine	Genitourinary	Musculoskeletal
Abdominal pain	Cold intolerance	Painful urination	Joint pain
Blood in stool	Heat intolerance		Joint stiffness
Heartburn			Joint swelling
Nausea			
None	None	None	None

Skin	Neurological	Hematologic	Psychiatric
Rash	Headaches	Enlarged lymph nodes	Nervous/anxious
	Numbness	Easy bruising	Depression
	Weakness	Clotting problem	
	Memory loss	Excessive bleeding	
None	None	None	None

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:
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:		

Completed By:

Patient Signature: _____ Date: _____

Reviewed By:

Provider Signature: _____ Date: _____