

New Patient Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone:AM \_\_\_\_\_ PM \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact Name & Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_

Address & Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_

Address & Phone \_\_\_\_\_

Reason for visit \_\_\_\_\_

Please describe your how and when your symptoms began \_\_\_\_\_

Please describe any previous tests (X-ray, CT scan MRI ,EMG etc) or treatments (Surgery, Injections, Medications and Therapy etc) you have had for this condition:

Please describe what makes the symptoms worse: sitting standing rest heat cold walking exercise sex touch Other: \_\_\_\_\_

Please describe what makes the symptoms better: sitting standing rest heat cold walking exercise sex touch Other: \_\_\_\_\_

**MEDICAL HISTORY:** Please write if you have had any Medical Illnesses / Problems

- Diabetes
- Hypothyroid
- Depression
- Sleep apnea
- Seizures
- Ulcers
- High Blood Pressure
- Osteoporosis
- Anxiety Disorder
- Liver disease
- Multiple sclerosis
- Heart Disease
- Arthritis
- Head Injury
- Kidney disease
- Stroke
- Rheumatoid Arthritis / Lupus / Gout or other connective tissue disorder
- Other \_\_\_\_\_

**Surgical History:** Please write if you have had any surgeries and write date of surgery

- Cardiac Bypass or Stent
- Gallbladder surgery
- C – section
- Pacemaker
- Appendectomy
- Hysterectomy
- Organ transplant
- Amputation
- Joint Surgery \_\_\_\_\_
- Spine Surgery \_\_\_\_\_
- Other surgery \_\_\_\_\_

Are you pregnant?  Yes  No  Unsure    Date of last period \_\_\_\_\_

**Allergies:**  None known    Medication allergy to \_\_\_\_\_  
Food \_\_\_\_\_ Environmental/Latex \_\_\_\_\_ IV contrast \_\_\_\_\_  
Type of reaction \_\_\_\_\_

Please list ALL the Medications you are taking Use back of page if needed.

Medication	Dosage	How long have you been taking this Medication?

**Family History:** Please write if any one in your immediate family has any of these

- illnesses:  None/ don't know  Heart Disease  Alcoholism  Depression  Cancer
- Multiple Sclerosis
  - Drug use
  - Diabetes
  - Bipolar disorder
  - Parkinsonism
  - Rheumatoid Arthritis / Lupus / Gout or other connective tissue disorder
  - Other \_\_\_\_\_

**Review of Systems**

	Yes	No		Yes	No
<b>Constitutional symptoms</b>			<b>Genitourinary</b>		
Fever/chills	_____	_____	Urinary frequency	_____	_____
Weigh loss/ gain	_____	_____	Urinary pain/blood	_____	_____
Fatigue	_____	_____	Urinary incontinence	_____	_____
Night sweats	_____	_____	Urinary retention	_____	_____
<b>Skin</b>			<b>Gynecologic</b>		
Rashes or color changes	_____	_____	Currently pregnant	_____	_____
Itching or dryness	_____	_____			
<b>Eyes</b>			<b>Musculoskeletal</b>		
Visual changes	_____	_____	Joint pain swelling	_____	_____
			Muscle pain/cramps	_____	_____
<b>Ears, Nose, Mouth, Throat</b>			<b>Neurological</b>		
Hearing Changes	_____	_____	Headaches/Dizziness	_____	_____
Dentures	_____	_____	Numbness/Tingling	_____	_____
			Weakness/Paralysis	_____	_____
<b>Cardiovascular</b>			Tremor		
Chest pains or palpitations	_____	_____	Loss of balance/falls	_____	_____
Leg pain w/ walking	_____	_____	Are you	_____	<b>R handed</b>
				_____	<b>L handed</b>
<b>Respiratory</b>					
Cough	_____	_____	Anxiety	_____	_____
Shortness of breath	_____	_____	Depression	_____	_____
Wheezing	_____	_____	Difficulty sleeping	_____	_____
Snoring	_____	_____			
<b>Gastrointestinal</b>					
Swallowing difficulty	_____	_____			
Heartburn	_____	_____			
Constipation	_____	_____			

**Other symptoms not listed above:** \_\_\_\_\_

**Social History:** Are you currently employed ? Yes No As? \_\_\_\_\_

If you are no longer working why did you stop and do you expect to return to work?

Are you on disability?(start date/rating)\_\_\_\_\_

On workmen's compensation?(start date)\_\_\_\_\_

Do you have any litigation pending relating to your medical condition? \_\_\_\_\_

Are you? Married Single Divorced Widowed/Widower

Does anybody else live in your home? \_\_\_\_\_

Home description: Handicapped Accessible \_\_\_\_\_

Number of Stairs to Enter and to other floors \_\_\_\_\_

Smoking History  none  ex-smoker  current \_\_\_\_\_

Drinking History none  ex-drinker  current \_\_\_\_\_

Drug Use none current past cocaine marijuana heroin Other \_\_\_\_\_

Have you ever been addicted to prescription drugs  Yes  No

If yes, please elaborate \_\_\_\_\_

**Functional History:** How do your symptoms affect your daily activities? \_\_\_\_\_

Do you use any assistive devices? none cane walker crutches wheelchair back brace leg brace Other \_\_\_\_\_

Do you have a home health aide? No Yes If yes please elaborate on the number of days and hours per week and what they help you with \_\_\_\_\_

Other comments or concerns you wish to address with the physician \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete the next page if you have pain

**Pain Questionnaire**

Where is your worst pain? \_\_\_\_\_

Does your pain radiate? To R arm L arm R leg L leg other \_\_\_\_\_

Is the pain: sharp dull burning aching stabbing shooting throbbing  
cramping electric intermittent steady superficial deep Other \_\_\_\_\_

Please rate your pain on a scale of 0-10 with 0 being no pain and 10 the worst pain imaginable.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

How and when did your pain begin? \_\_\_\_\_

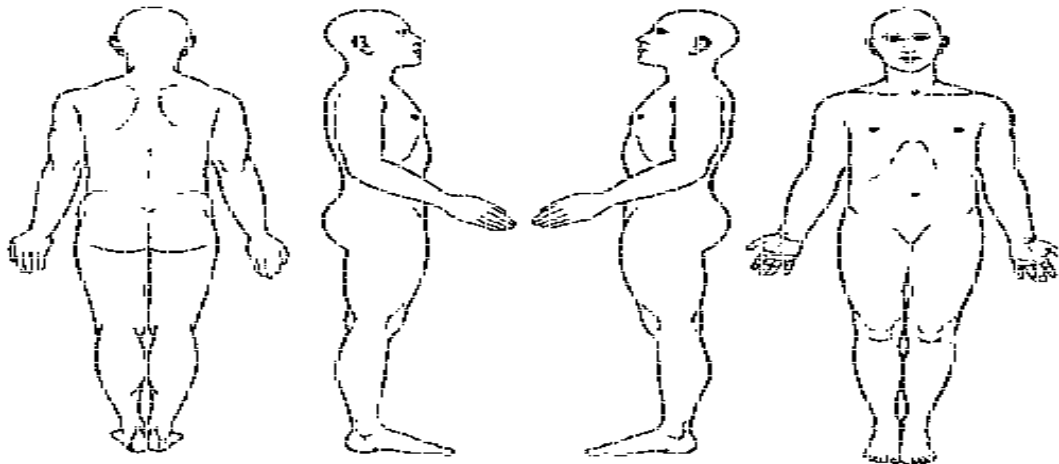
What is your average pain? \_\_\_\_\_

How long has your pain been at this level? \_\_\_\_\_

When and what is your least pain? \_\_\_\_\_

When and what is your worst pain? \_\_\_\_\_

On diagram below please mark the areas where you have pain Use the symbols to indicate where your pain is: Ache: AAA Burning:XXX Numbness:OOO  
Pins & Needles: ..... Stabbing:///// Throbbing +++ Cramping CCC



L Back R

R Side

L Side

R Front L

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_