New Patient Questionnaire

Physiatry

HOSPITAL FOR SPECIAL SURGERY

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

Which Physician are you here to see today? _____

Referring Physician: _____

Chief Complaint

What is the reason for your visit? _____

_____

_____

Please describe your symptoms:

Aching	Stiffness	Stabbing
Sharp	Dull	Tingling
Catching	Pins and Needles	Other:

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

0	1	2	3	4	5	6	7	8	9	10

Average 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):

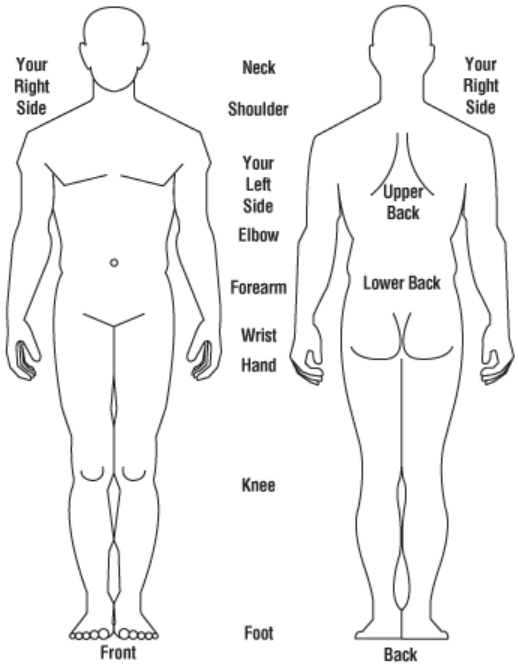
0	1	2	3	4	5	6	7	8	9	10

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

0	1	2	3	4	5	6	7	8	9	10

Please mark on the diagram where you are experiencing pain, numbness, and/or tingling.

Use the following symbols on the diagram: Pain = 1, Numbness = 0, Tingling = X



When and how did this condition start? _____

_____

Was this a result of an auto accident? Yes No

Was this a work related injury? Yes No

Do you have a lawsuit related to this? Yes No

What makes it better? _____

_____

What makes it worse? _____

_____

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

Type	Date Range	Location/Results	Effective?
Medication:			Yes No
Medication:			Yes No
Injection (what kind?):			Yes No
Injection (what kind?):			Yes No
Physical Therapy			Yes No
Surgery			Yes No
Other:			

Have you had any of the following tests for this condition?

Type	Date	Results
X-Ray		
MRI		
CT Scan		
Other:		

Immunizations and Falls Screening (age 65 and older)

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

Allergies and Medications

Please list any allergies and reactions if known:

Allergy	Reaction
1.	
2.	
3.	

Please list your current medications (including vitamins and supplements):

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medical History

Please list your past or current medical conditions below (even if controlled, e.g. high blood pressure):

_____

_____

_____

Family History

Please list any medical conditions of your family members (mother, father, etc.)

_____

_____

Surgical and Hospitalization History

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

Social History

Are you a tobacco user?	Yes No	How many packs per day?
Do you consume alcohol?	Yes No	How many drinks per week?
Do you use any recreational drugs?	Yes No	What kind(s)?
What is your dominant hand?	Left Right Ambidextrous	
Are you currently working?	Yes No	Profession:
What is your marital status?		
Do you have any children?	Yes No	How many?
Are you physically active?	Yes No	What activities/sports?

How do you sleep?	Good	Fair	Poor
On average, how many hours of sleep do you get per night?			
How is your diet?	Good	Fair	Poor
What are your stressors?	Work	Commute	Family
Other stressors:			

Review of Systems

Do you currently have, or have you had any of the following in the past year *(select all that apply for each section):*

Constitutional	Hematological	Respiratory	Skin
Vomiting	Adenopathy	Chronic Cough	Discoloration
Chills	Easy Bruising/Bleeding	Shortness of Breath	Bruising
Nausea	DVT	Wheezing	Non Wound Healing
Fever	Anemia	Difficulty Breathing	Rash
Sleep Difficulty			
Fatigue			
None	None	None	None

HEENT	Cardiovascular	Endocrine/Hormonal	Musculoskeletal
Double Vision	Chest Pain	Intolerance of Cold	Decreased ROM
Headaches	Edema	Intolerance of Heat	Joint Redness
Hearing Loss	Palpitations	Weight Loss	Muscle Pain
Hoarseness		Weight Gain	Joint Swelling
Runny Nose		Hair Changes	Muscle Cramps
		Nail Changes	Muscle Weakness
			Leg Cramps
			Joint Stiffness
None	None	None	None

Gastrointestinal	Genitourinary	Neurological	Psychiatric
Abdominal Pain	Bladder Incontinence	Paralysis	Depression
Bowel Habits Change	Urinary Retention	Dizziness	Anxiety
Trouble Swallowing	Irregular Menses	Weakness	Memory Loss
Heartburn/GERD	Non-menstrual Bleeding	Loss of Balance	Substance Abuse
	Pelvic Pain	Numbness	Suicidal Ideas
	Urinary Urgency	Paresthesias	
	Urinary Leakage	Seizures	
	Erectile Dysfunction	Difficulty Walking	
	Decreased Libido		
	Retrograde Ejaculation		
None	None	None	None

Please list any questions/goals you have for this visit: