Patient Questionnaire

Office of Peter J. Moley, M.D.

HOSPITAL FOR SPECIAL SURGERY

Your Name: _____ E-Mail Address (REQUIRED): _____

Referring Physician: _____

Preferred Pharmacy w/ Approx. Address (REQUIRED): _____

Chief Complaint

What part(s) of the body are you being seen for? _____

Please describe: _____

_____

Please describe your symptoms:(check all that apply)

Aching	Stiffness	Electrical
Sharp Pain	Dull Pain	Tingling
Catching	Clicking	Numbness
Burning	OTHER:	

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

0	1	2	3	4	5	6	7	8	9	10

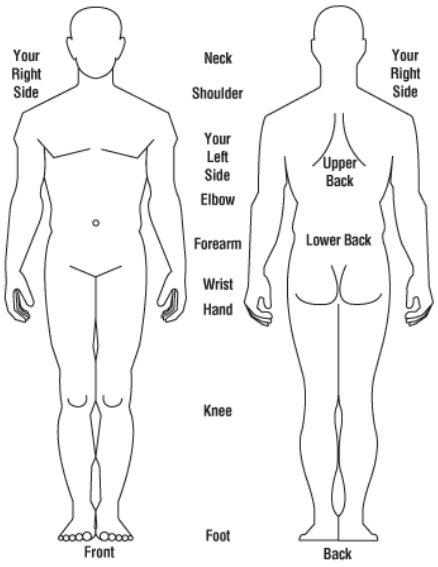
Pain Level at Best (no pain 0 – 10 highest):

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 (REQUIRED):



When did this condition start? _____

Please explain how this condition started: _____

_____

Does anything make the pain better? _____

_____

Does anything make the pain worse? _____

_____

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

CHECK HERE (or circle)	Date(s)	Please Describe
Medications		
Injections		
Surgery		
Physical Therapy		
X-Ray		
MRI		
CT Scan		
Myelogram		
Bone Scan		
Other		

Have you experienced any of the following? (check all that apply)

Weight Loss	Fever/Chills	Breathing Problems
Heart Problems	Bowel/Bladder Changes	Numbness
Weakness	Night Pain	Morning Stiffness
Stomach Problems		

Are you currently on any blood thinners (i.e. Coumadin)? _____

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

Do you have any allergy to contrast dyes? Yes No

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

Medical History

Please select (circle / check) any past medical conditions that you have had below:

Anxiety	Heart Attack	Open Wounds/Ulcers	Pulmonary Embolus
Arrhythmia (Irregular heartbeat)	Heart Disease	Osteoarthritis	Reflex Sympathetic Dystrophy
Asthma	High Blood Pressure	Osteopenia	Reflux
Bleeding Problems	High Cholesterol	Osteoporosis	Rheumatoid Arthritis
Blood Clots (DVT)	Infection	Peripheral Vascular Disease	Seizures
Cancer	Kidney Disorders	Pneumonia	Stroke
Diabetes	Lung Disease	Psychiatric Illness (Depression)	Ulcers
List any others →			

Surgical History

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

Family History (check all that apply; please be as detailed as possible):

Relationship	Name	Status	No Known Problems	Add Problem	Abnormal bleeding	Anesthesia problems	Arthritis	Asthma	Birth defects	Cancer	Clotting disorder	Depression	Diabetes	Early death	Eating disorder	Heart disease	Hip fracture	Hyperlipidemia	Hypertension	Kidney disease	Liver disease	Lupus	Mental illness	Osteoporosis	Rheumatoid Arthriti...	Substance Abuse	Stroke	Vision loss
Mother																												
Father																												
Sister																												
Brother																												
Daughter																												
Son																												
Mat Aunt																												
Mat Uncle																												
Pat Aunt																												
Pat Uncle																												
MGM																												
MGF																												
PGM																												
PGF																												
Neg Hx																												

Social History

Are you a tobacco user? Yes No

If yes, how many packs per day? _____

Do you consume alcohol? Yes No

If yes, how many drinks per week? _____

Marital Status:

Single Married Divorced Widow/Widower

Employment Status:

Employed (Part-time / Full-time) Student (Part-time / Full-time) Retired Do not work

Review of Systems (continued on next page):

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

Constitutional	Hematological	Respiratory	Skin
Vomiting	Adenopathy	Chronic cough	Discoloration
Chills	Easy bleeding	Shortness of breath	Bruising
Nausea	DVT	Wheezing	Non wound healing
Fever	Anemia	Difficulty breathing	Rash
Sleep Difficulty			
Malaise/Fatigue			
Night sweats			
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	Decreased libido	Dizziness	Anxiety
Trouble swallowing	Urinary difficulty	Weakness	Memory loss
Heartburn/GERD	Erectile dysfunction	Loss of balance	Substance abuse
	Retrograde ejaculation	Numbness	Suicidal ideas
	Urinary retention	Paresthesia's	
	Urinary urgency	Seizures	
		Difficulty walking	
None	None	None	None